

Digitized by the Internet Archive
in 2016

<https://archive.org/details/journalofindiana712unse>

July 1978 • Vol. 71 • No. 7

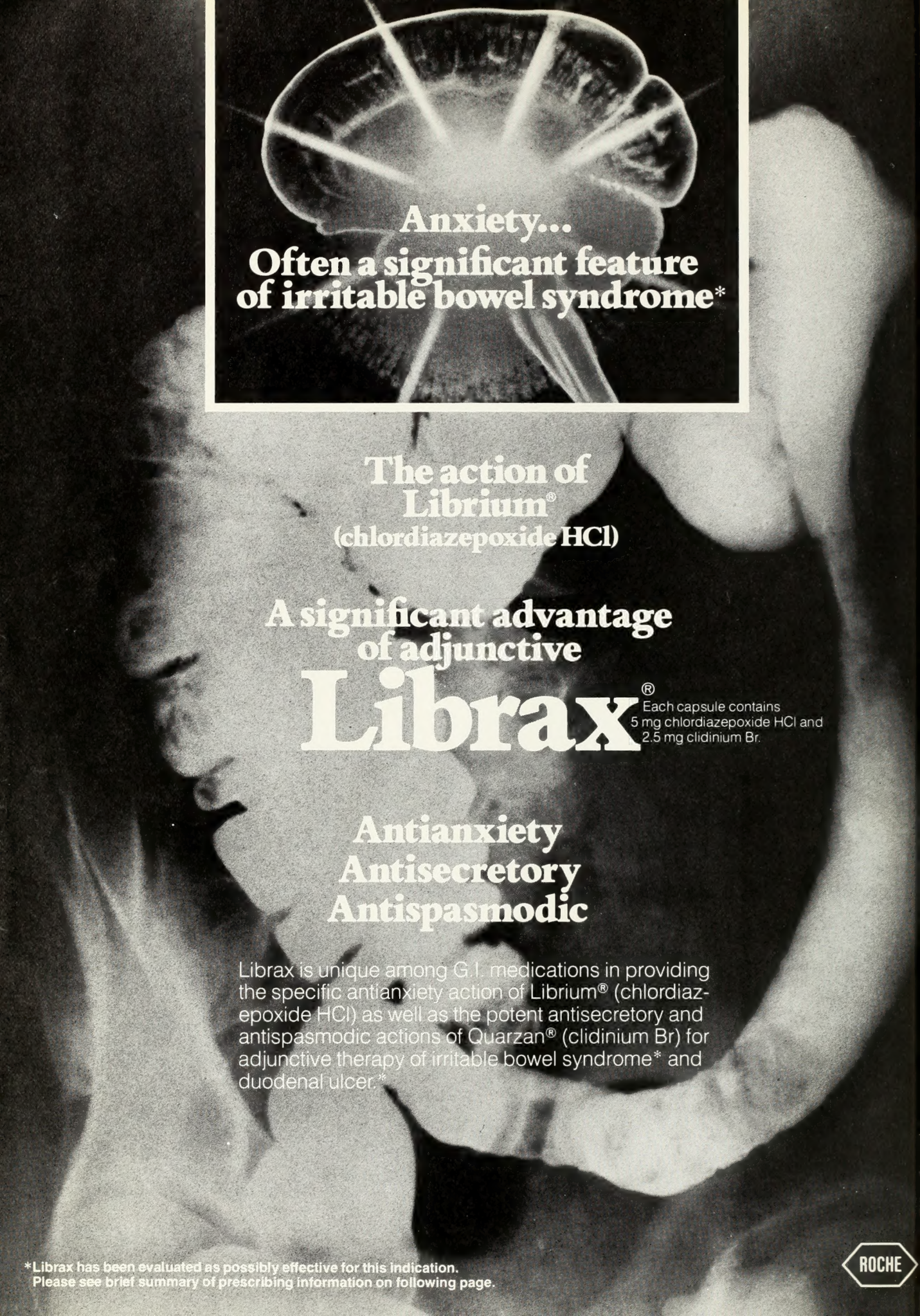
The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION



LIBRARY
U.C. SAN FRANCISCO

JUL 22 1978



Anxiety...
Often a significant feature
of irritable bowel syndrome*

The action of
Librium®
(chlordiazepoxide HCl)

A significant advantage
of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

Antianxiety
Antisecretory
Antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

ROCHE

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

WHAT'S NEW?

Ultra-Violet Products has a lightweight, battery-operated ultra-violet light called BLAK-RAY®, ideal for detecting ordinarily invisible unsanitary conditions such as rodent urine, hair, some greases and oils, urine deposits and hard water scale in restaurants and public lavatories. The ML-49 is ideal for inspections of places which are inaccessible to line-operated lamps.

* * *

Norwich-Eaton Pharmaceuticals is introducing a new, disposable delivery system for enteral hyperalimentation. The Vivonex® Delivery System is a leak-proof plastic system which allows slow, continuous drip of Vivonex via small bore feeding tubes with gravity flow; there's no need for pumps. The system has a meter that allows adjustment of flow rates to an accurate degree.

* * *

Jefferson Industries is introducing the Econo-Float Water Flotation Mattress. It is inexpensive, yet effective, for the treatment and prevention of decubitus ulcers. Internal baffles reduce water motion and contribute to stable support. The mattress is made from an exclusive formulation of vinyl and nylon that was developed to prevent small repairable punctures from becoming large holes.

* * *

Paddock Laboratories has introduced GLUTOSE, a concentrated solution of glucose for treatment of insulin hypoglycemia. It is packaged in a 1-ounce container that may be carried in the pocket and opened easily and quickly if needed. The monosaccharide provides relief more quickly than does sucrose.

* * *

Parke-Davis, at the request of the FDA, has stopped the distribution of Benylin Cough Syrup as an over-the-counter product. In the future Benylin Cough Syrup will be dispensed only by a physician's prescription.

* * *

Medical Research Laboratories has announced a new, lightweight, completely self-contained life-saving system for emergency services. The 450 SL is contained in a durable case and includes a monitor scope, a defibrillator and a chart recorder. The total weight is less than 25 lbs. Other features are a trace HOLD, a digital heart rate meter and optional heart rate alarm. It will operate from fully charged new batteries for three hours and can be 80% recharged in one hour.

* * *

Du Pont Photo Products Department is introducing a new "Cronex" extremity imaging system. It can reduce radiation as much as 90% as compared with conventional methods that do not use intensifying screens. The radiographs are of improved quality.

CONTINUED ON PAGE 664

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

344844

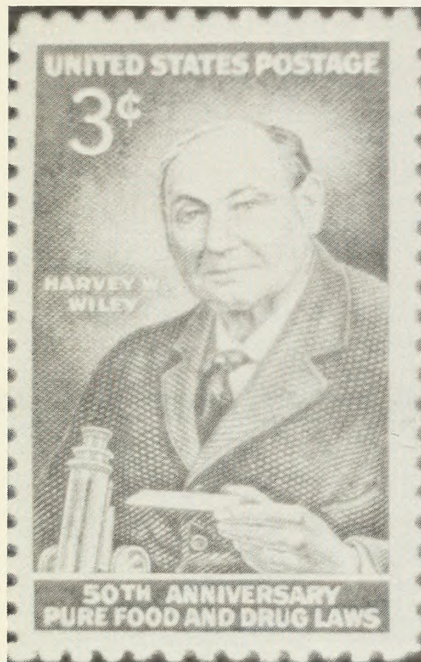
ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis



Harvey W. Wiley, M.D. (1844-1930) was an 1871 graduate of the Indiana Medical College, featured in this column for the past two issues. How it happened that his picture appeared on a U.S. postage stamp is what this story concerns.

Our photo of Dr. Wiley, together with the information that follows, was obtained from a biographical scrapbook compiled during his lifetime by William N. Wishard, Sr., M.D., president of ISMA in 1898. (This book is kept at the Indiana Medical History Museum).

Dr. Wiley was born Oct. 18, 1844 in Kent, Ind. Twenty years later, as a member of the sophomore class at Hanover College, he heard President Lincoln's call for volunteers for 100 days. He enlisted and served with his regiment in Kentucky and Tennessee. He later returned to Hanover, and was graduated with the Class of 1867.

He taught school a year in northern Indiana but, in 1868, he began studying medicine in the office of Dr. F. E. Hampton in Milton, Ky., across the river from Madison. Dr. Wishard reported that Dr. Wiley "was chosen tutor in Latin and Greek in the Northwestern University (now Butler) where he spent three years teaching (these subjects), at the same time pursuing his studies at the Indiana Medical College. . . ."

Since Dr. Wiley had already given special attention to chemistry, in 1872 he was appointed professor of the Indiana Medical College's chemistry department. He didn't actually accept the position until 1873 because he spent the intervening year at Harvard earning a degree in science.

Chemistry was to become Dr. Wiley's forte. While serving as professor of the Indiana Medical College's chemistry department, he filled the same position at Northwestern Christian University, where he had previously taught Latin and Greek. In 1874 he was appointed professor of chemistry at Purdue University, where he served nine years. In 1883, he became chief chemist in the Agricultural Department of the United States and served in that Washington position 29 years.

Dr. Wiley married the former Miss Anna Kelton in 1911 and they had two sons, Harvey in 1912, and John in 1914.

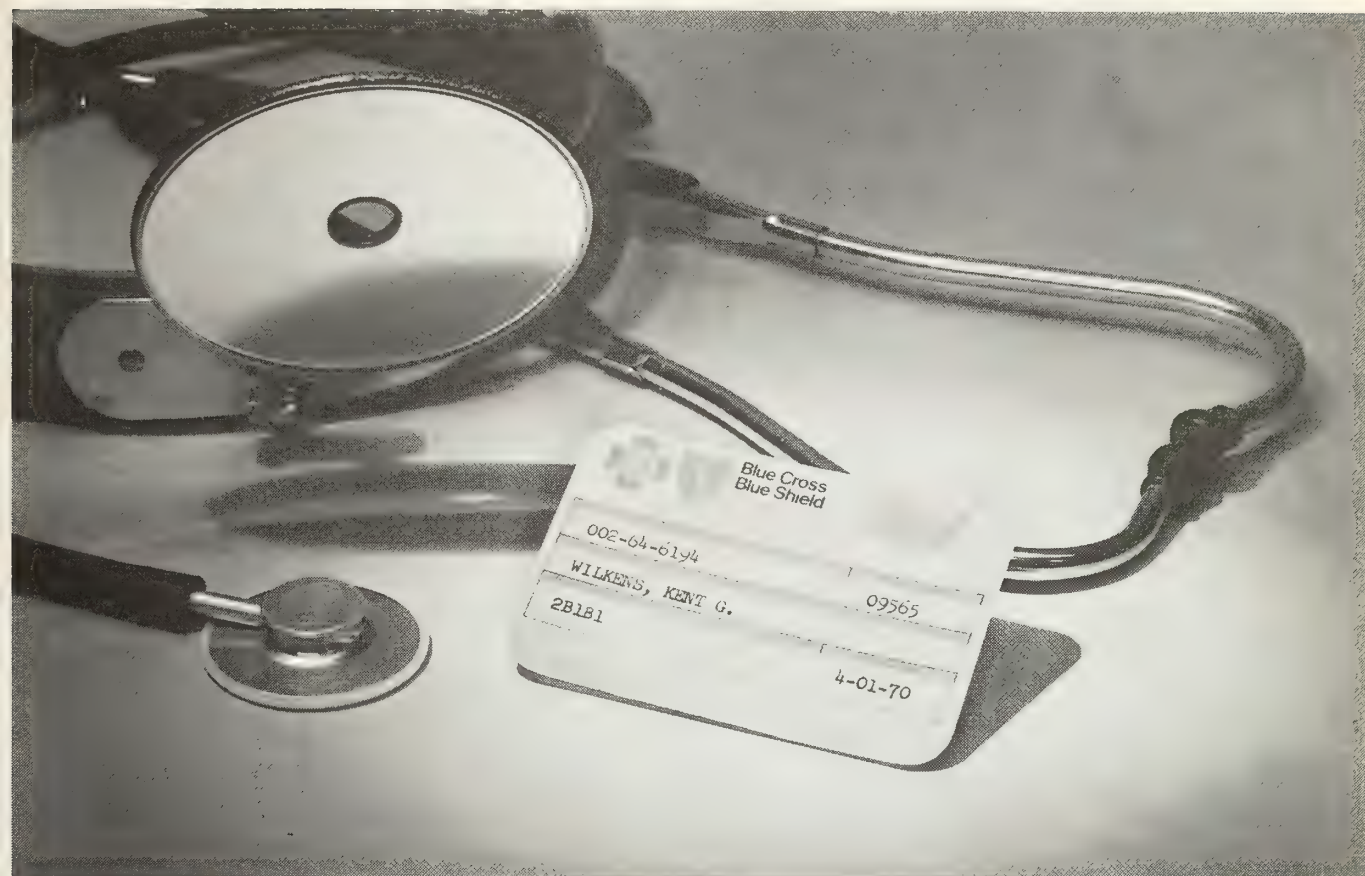


Of Dr. Wiley's work as chief chemist, Dr. Wishard noted, "'Put it on the label' was a motto guaranteeing purity of products, which finally he had enacted into law. . . ."

So it was that the Pure Food and Drug Act of 1906 became known as "Dr. Wiley's Law." And in 1956, on the 50th anniversary of this law, the U.S. Postal Service honored Dr. Wiley by issuing a three-cent commemorative stamp bearing his likeness.

ISMA ANNUAL MEETING
October 22-25 • Clarksville

Take advantage of a great association!



Get these special benefits – available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage – and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association – entitling you to special group rates for these benefits:

- One full year in-hospital care
- 100% semi-private room and hospital extras
- Allowances for surgery, anesthesia, obstetrics, medical visits, diagnostic and radiation therapy
- \$250,000 Major Medical Benefits

That's not all. You also benefit from the immediate recognition and automatic acceptance of the Blue Cross and Blue Shield membership card. The special rates available through the Indiana State Medical Association membership make this coverage your best investment in personal protection. You can get it – now.

Call or write: Mrs. Kathryn Eads,
Professional Accounts, Blue Cross and Blue
Shield of Indiana, 120 W. Market Street,
Indianapolis, Indiana 46204. Telephone: (317)
263-4925.

120 West Market St.
Indianapolis, Ind. 46204

® Reg. Mark Blue Cross Assn.
* Reg. Serv. Mark Nat'l Assn.
of Blue Shield Plans



**Blue Cross
Blue Shield**
of Indiana

Contents

SCIENTIFIC ARTICLES

- 678 **Urinary Calculi**—Richard Bloch, M.D., Lafayette (Sixth Continuing Medical Education Article)
- 681 **Brown Recluse Spider Bite**—Philip C. Anderson, M.D., Columbia, Mo.
- 684 **Plication of Rectal Mucosa**—Richard H. Appel, M.D., Indianapolis
- 686 **Newborn Thyroid Screening**—Ralph J. Wynn, M.D., Indianapolis
- 689 **Screening for Congenital Hypothyroidism**—Tjien O. Oei, M.D., Indianapolis
- 692 **Rapid Detection of Hemoglobin S**—Wei-Ping Loh, M.D., Gary
- 694 **Reconstructive Ear Surgery**—George W. Hicks, M.D., Indianapolis
- 700 **The Treatment of Urticaria**—Jere D. Guin, M.D., Kokomo

EDITORIALS

- 644 **Editorial Notes**
- 646 **A Deterrent to Government Price Controls**—AMA
- 648 **M.D. 1978: The Tarnished Image**—L. A. Arata, M.D., Shelbyville

SPECIAL FEATURES

- 650 **Indiana Voluntary Effort**
- 659 **A Message for Reference Committee Members**
- 660 **The Citizen's Power is Being Undermined by Federal Action**—Governor Otis R. Bowen, M.D.
- 674 **From Jasper to Africa . . . and Back**: Charles H. Klammer, M.D.
- 706 **The Scalpel and the Pen: Tobias George Smollett**—Rodney A. Mannion, M.D., LaPorte

DEPARTMENTS, MISCELLANEOUS

- 639 **What's New?**
- 640 **Museum Notes**—Charles A. Bonsett, M.D., Indianapolis
- 652 **Month in Washington**
- 663 **IMPAC: As I See It**—Fred Smith, M.D., Chairman
- 666 **Auxiliary Report**—Mrs. G. Beach Gattman, President
- 671 **Tax Tips**—Lawrence A. Jegen III, J.D., Indianapolis
- 673 **From The Journal 50 Years Ago**
- 702 **Cancer Corner**—William M. Dugan, Jr., M.D., Indianapolis
- 705 **There's a Word for It**—Richard J. Noveroske, M.D., Evansville
- 710 **Future File**
- 712 **Book Reviews**
- 714 **News Notes**
- 722 **Obituaries**

ABOUT THE COVER

The *Miss Madison*, owned by the City of Madison, Ind., will appear in the annual Madison Regatta Sunday, July 9. The boat, believed to be the only community-owned craft of its type in the world, will race in the unlimited hydroplane category. Under previous owners, the *Miss Madison* was national champion twice. PHOTO COURTESY OF INDIANA DEPARTMENT OF COMMERCE.



EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue.

Representative for national advertising is the State Medical Journal Advertising Bureau, 711 South Blvd., Oak Park, Ill. 60302.

Annual subscription rates: ISMA members, \$8, included in annual membership dues; ISMA senior members, \$10; Libraries, \$12; all others, \$14. Additional postage: Canada and PUAS countries, \$2; Foreign, \$3. Subscriptions are renewable in July and January.

Entered as second class matter January 25, 1933, at the Post-office at Indianapolis, Indiana.

Copyright 1978 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian St., Indianapolis 46208. All material subject to this copyright may be copied for the noncommercial purpose of scientific or educational advancement.

Second class postage paid at Indianapolis, Indiana, and at additional mailing office.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

Our International Standard Serial Number is ISSN 0019-6770.

Indexed in Index Medicus and Hospital Literature Index.

100 mg

250 mg

500 mg



Tolinase[®]

tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

© 1977 THE UPJOHN COMPANY

EDITORIALS

Editorial Notes . . .

A poll by Louis Harris has shown that a majority of hospital industry leaders (75 to 19%) and a majority of the public (73 to 15%) think Congress should give the industry a chance to voluntarily control its costs before enacting government controls. "People are saying it is possible that voluntary cost containment of hospitals can work," Harris said. "They are not saying that it will work. . . . As much as people may have apprehensions over the way health care and hospitals are run these days, they also have deep worries over what would happen if the hand of government were increased."

Television violence dropped sharply last year from the record high reached in 1976, according to a study conducted by researchers at the University of Pennsylvania, Annenberg School of Communications. The study also showed that NBC was the most violent network in the 1977 fall season, while ABC edged out CBS as the least violent. The study was partially funded by a \$98,438 grant from the AMA, allocated over a three-year period and reviewed annually. The grant was renewed this year for a one-year period in the amount of \$32,812.

Community hospitals in the U.S. decreased their rate of spending from 16.8% in January 1977 to 13.5% in January 1978. Michael Bromberg, executive director of the Federation of American Hospitals, is calling upon HEW Secretary Joseph Califano to acknowledge the downward trend and to stop name calling and unwarranted criticism of the nation's hospitals.

Tranquilizers may sustain alcoholism. AMEP-O-GRAM, the newsletter of the Addiction Medical Education Program of Evansville, reports from an article in SCIENCE NEWS that experiments with animals suggest that, instead of helping the alcoholic craving, diazepam and related drugs may actually sustain it. The use of such drugs to treat human alcoholics may be counter-productive.

Indiana Medical Foundation Memorials

The Indiana Medical Foundation, Inc., was formed by the Indiana State Medical Association for charitable, education and scientific purposes. It provides financial assistance to support the educational mission of The Journal. Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code. Gifts are deductible for Federal estate and gift tax purposes.

The Foundation is pleased to acknowledge the receipt of gifts in remembrance of the following:

Jacob K. Berman, M.D.

Joseph Gibbs, M.D.

Mrs. Margaret E. Moore Manion

George Garceau, M.D.

William R. Tindall, M.D.

Joseph Waring, M.D. (South Carolina)

Glen Ward Lee, M.D.

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 3935 N. Meridian Street, Indianapolis 46208.

Consulting Editors: A. W. Cavins, M.D., R.R. 25, Box 172, Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1, Box 202, Gaston 47342; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne 46802; I. W. Wilkens, M.D., 4820 E. Pleasant Run Pkwy., N. Dr., Indianapolis 46201; W. D. Snively, Jr., M.D., R.R. 1, Box 227, Evansville 47712; Charles A. Bonsett, M.D., 6133 E. 54th Place, Indianapolis 46226.

Editorial Board:

Steven C. Beering, M.D., Indianapolis	Dec. 31, 1978
Paul S. Rhoads, M.D., Richmond	Dec. 31, 1978
Elton Heaton, M.D., Madison	Dec. 31, 1979
Rodney A. Mannion, M.D., La Porte	Dec. 31, 1979
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1980
Wei-Ping Loh, M.D., Gary	Dec. 31, 1980

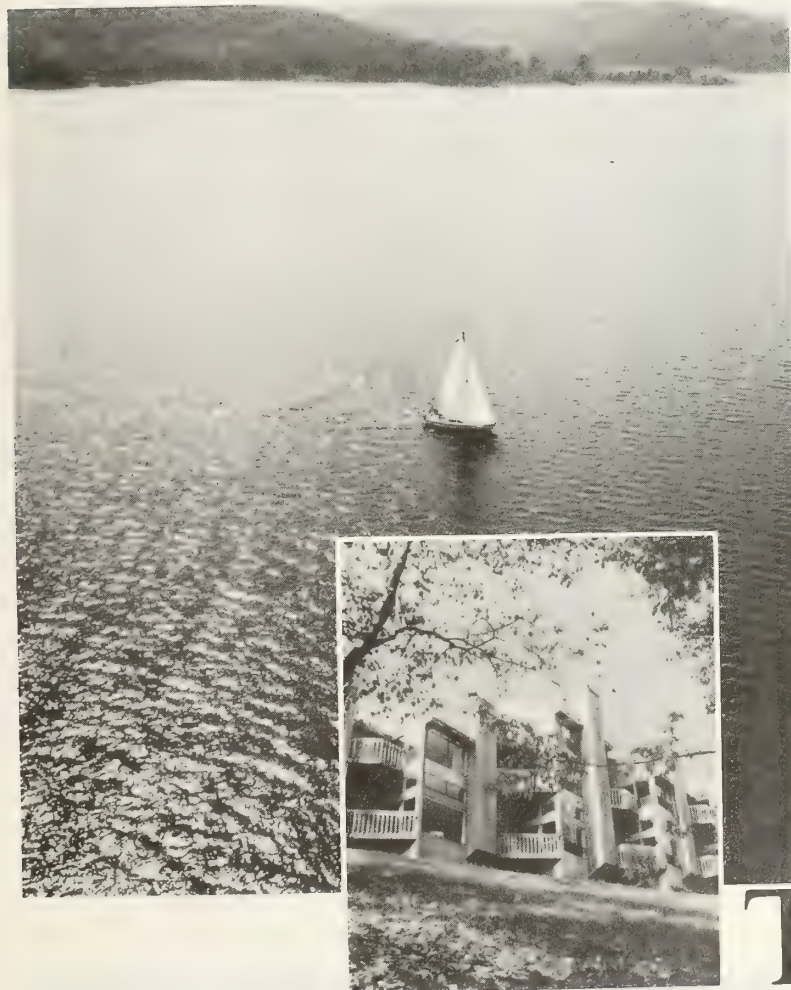
Term Expires

Business Manager: Donald F. Foy

3935 N. Meridian, Indianapolis, Ind. 46208

Managing Editor: Martin T. Badger

65 Miles from Indianapolis, there's a fabulous residential resort called The Pointe. You can call it home.



You're lucky. Living in Indiana puts you within comfortable weekend distance of a world of recreational and residential pleasure other people can only visit on special occasions.

Your special occasions can happen 52 times a year. When you can enjoy a world of beauty and recreation overlooking 22,000 acres of shimmering lake, set amid the hills and woodlands of Hoosier National Forest. It's a resort world, complete with every facility, from yacht club and marina to restaurant and lounge. Beaches, boating, fishing. Living.

It's a private world of community recreation. The Pointe's own PGA championship golf course, swimming pool, tennis courts, gourmet dining and conviviality in the clubhouse's restaurant and lounge.

And a residential world — an almost endless variety of holiday and full-time homes. Comfortable one-bedroom vacation homes to year-round family homes up to 3 bedrooms. From as little as \$29,990 to \$79,990. Four distinctive communities, each with its own variety of designs.

Discover it for yourself. Call (812) 824-7022, collect. Or drive out SR-37 South to the Harrodsburg exit and follow the signs. Models are open 10 till 7 daily. Start living a full-time vacation.



The Pointe on Lake Monroe

An AMA Editorial

A Deterrent to Government Price Controls

"The alternative to increasing government regulation is a system of incentives for economy and fair-market competition as recommended by your National Commission on the Cost of Medical Care."—**Alain G. Enthoven, Stanford University economist**

The AMA-created National Commission on the Cost of Medical Care has opened up a new horizon by emphasizing the need to restore the concept of free-marketplace choice in health-care delivery.

What does that mean?

Well, picture the delivery system as a marketplace where producers and consumers handle their transactions through insurers, private and public. The Cost Commission report recommends that producers and consumers have direct impact on decisions made in their behalf.

Consumers want to buy services at a lower annual rate of cost growth than the 11% it has averaged since 1966.

However, the marketplace right now is not functioning well. It was flexible in the days when consumers paid the producer directly. But the patterns of coverage offered by today's middleman insurers are largely standardized in benefits and therefore in costs.

The Cost Commission report suggests ways in which those patterns can be stimulated to offer a latitude and freedom of choice.

For instance, employees could choose among health-care plans in terms of premium price, whereas employer contributions to premiums would be the same for any plan. The employee selecting a plan less expensive than the employer contribution would either be reimbursed for the difference or receive additional benefits.

The report makes this general observation:

"Reliance on market mechanisms can lead to cost-effective production of output, and permit consumer preferences to play a key role in determining what goods and services are available."

Unfortunately, this leeway cannot control costs all by itself. Nor does the marketplace assure care to the poor and uninformed, and their health-care costs could continue to rise sharply.

Hence, there must be some reliance on provider self-regulation and on local regulation if the overall tab is to be kept in line. No federal controls are recommended by the report.

Self-regulation would include cost-containment initiatives in the private sector of care, among third-party payers, and in medical practice. Says the report:

"In the past, providers have considered primarily the medical needs of their patients. The Commission believes that providers must now take steps to make cost-effective utilization recommendations without sacrificing the quality of care. There are a number of programs that can be undertaken within the health-care system that are not dependent on major changes in the delivery system."

The chief value of the report is that it brings many ideas and groups together in a coordinated program for genuine action. Some of the ideas are old but have never been implemented. Group responsibilities include those placed on the consumer.

The upshot could be a momentum that would head off arbitrary, unwieldy federal formulas for cost containment. Developed after a year and a half of intensive study and effort, the Cost Commission report presents credible alternatives to those formulas.

ISMA ANNUAL MEETING
October 22-25 • Clarksville

To the physician whose practice needs a new perspective.

Look into Air Force Aerospace Medicine.

As an Air Force Flight Surgeon, you will have a truly general practice on the ground, while in the air you will fly with and observe air crew members — adding a new perspective to your medical career. The Air Force gives you the respect of your profession and the prestige of an Air Force officer. In addition to the numerous benefits of an Air Force career, you will also have the opportunity to compete with other

physicians for an outstanding education program. It's the way to pull your entire life into perspective — time for your family, time for yourself, and time to advance in your profession.

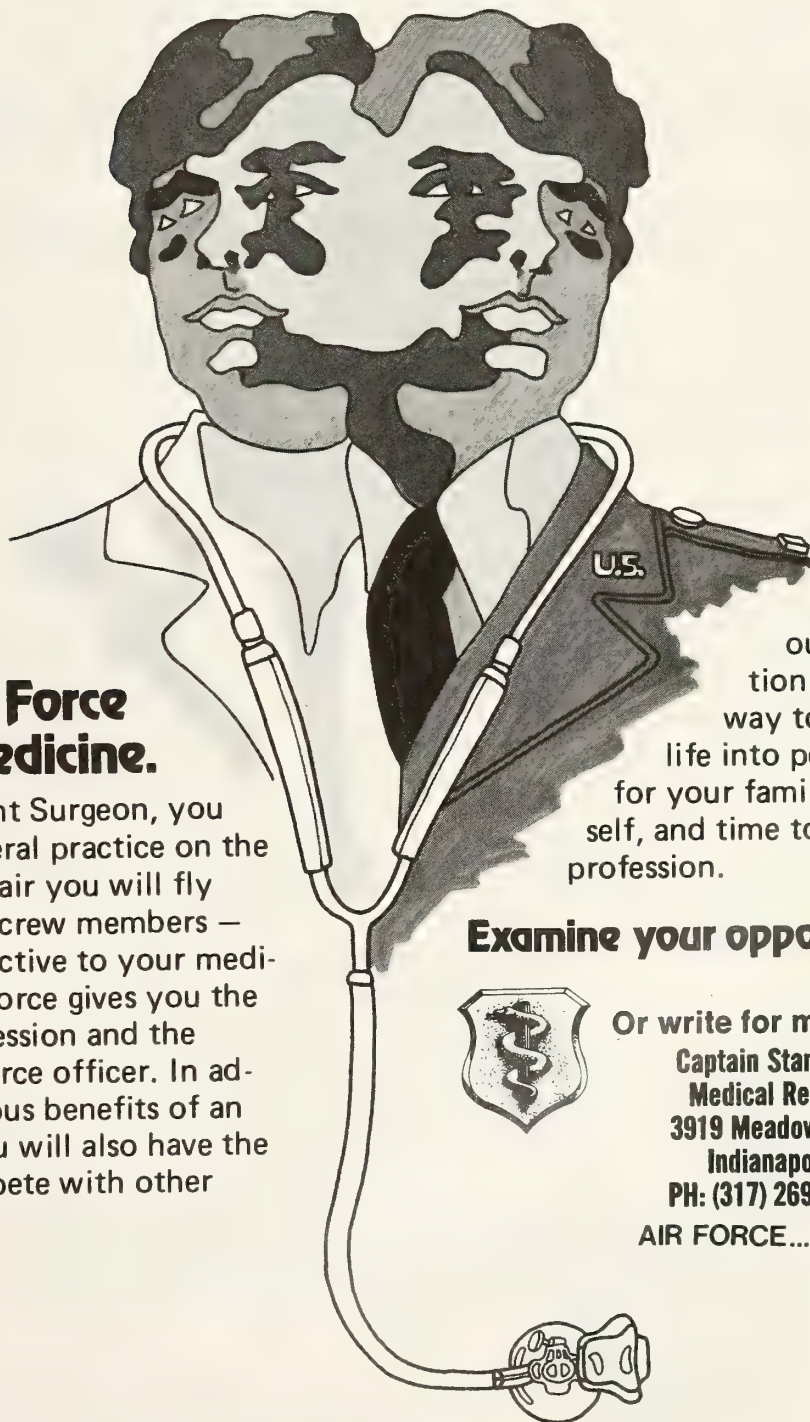
Examine your opportunities now



Or write for more information.

Captain Stanley M. Herndon
Medical Recruiting Office
3919 Meadows Drive, Suite 1
Indianapolis, IN 46205
PH: (317) 269-6624 (COLLECT)

AIR FORCE... A Great Way of Life



Guest Editorial

M.D. 1978: The Tarnished Image

L.A. ARATA, M.D.
Shelbyville

Historically in most cultures, the physician, the healer, has been a respected member. In many primitive cultures, the physician has been accorded status either just secondary to, or in some cases, above the chief. He has had the privilege of being above some of the taboos that limited action of the rest of society. It is from this view of the history of medicine that I look at the present, and try to look into the future.

As I look at Medicine-USA-1978, I find that we have a tarnished image. We are no longer revered by government or our patients, but are looked upon by some patients as a target for legal abuse, as well as looked upon by government leaders as a "whipping boy" to take the blame for almost all of society's ills. I ponder the *why* of this.

Medicine has traditions. There are always reasons for traditions. Reasons are sometimes forgotten long before the traditions are forgotten. When we throw traditions overboard or forget them, we may be forced to learn the hard way that there were reasons why the traditions existed for longer times than you or I will exist. The hard way of learning is, by definition, a painful way of learning. Perhaps some of the pain we are experiencing at present may be caused by our having forgotten our traditions.

One of our profession's great traditions, revered for two-plus millenia, has been the Hippo-

cratic oath. Its exhortation to do no harm, request help from the Deity, avoid abortions, and other guides to appropriate physician behavior seem to have been forgotten by too many of us in the last 20 or 30 years. This same 20- or 30-year period seems to coincide with our increasingly tarnished image. Was Hippocrates smarter than we? Is this a cause and effect phenomenon? Is there a connection? I suspect a cause and effect. Neither I nor anyone else can prove nor disprove it.

It makes me sad to read about abortionists accused of killing live aborted fetuses, of Medicaid mill rip-offs, of surgeons cutting for acute remunerative disease, of uncaring treatment of the sick, and many other facts or fancies involving our profession. Unfortunately, there seems to be a grain of truth in some of these accusations.

Just as all this makes me sad it angers the public and the public leaders. It encourages them to strike at all of us because a few of us have ignored our traditions. All of this convinces me that Pogo was correct and smart when he said several years ago "We have met the enemy and it is us." Doctors seem to be the worst enemies of doctors.

Perhaps if we physicians could again be physicians in the traditional way we might succeed in polishing our image to the luster it once had.

CORRECTION

The following is a correction to the article, "A Re-evaluation of Ephedrine/Theophylline Combinations in the Treatment of Asthma," by Irvin Caplin, M.D. and John T. Haynes, M.D. (THE JOURNAL, 71:492, May 1978):

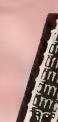
Under the subheading, "Additional Treatment," the first sentence is corrected to read: "When symptoms were not controlled, isoproterenol nebulization, followed by injections of epinephrine [not ephedrine, as stated] if needed, were given to patients."

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

 **Android**[®] / 5^{Buccal} mg. / 10^{Oral} mg. / 25^{Oral} mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Task Force on Health Care Costs Formed



Sharing a chuckle during an Indianapolis meeting of the Indiana Task Force on Health Care Costs are Eli Goodman, M.D. (left), ISMA president, and Arthur Miller, president of the Statewide Health Coordinating Council.

Indiana doctors and hospitals are spearheading a statewide voluntary effort aimed at slowing down the rate of increase of health care costs. The Indiana Hospital Association and the Indiana State Medical Association have formed an Indiana Task Force on Health Care Costs to serve as a statewide steering committee.

The committee brings together representatives of industry, labor, government, health insurance, the general public, hospitals and physicians to examine the causes of health cost inflation and ways to reduce the escalation.

"This is the first time such a broad-based approach has been used to attack the national problem of rising health care costs," according to Eli Goodman, M.D., Charlestown, president of the Indiana State Medical Association, who was elected Task Force chairman. The voluntary effort was officially launched in Indianapolis April 26.

Willis N. Zagrovich, president, Indiana State AFL-CIO, Indianapolis, was elected vice chairman. Roland E. Kohr, administrator, Bloomington Hospital, chairman of the Indiana Hospital Association, was elected secretary.

The Indiana initiative is part of a nationwide program, organized by the American Hospital Association, American Medical Association and the Federation of American Hospitals. It is endorsed by 50 states.

A hospital cost containment program has been in operation in Indiana for the past 17 years, under the Indiana Hospital Rate Review Program housed in Blue Cross of Indiana. The Rate Review Committee results will be part of the monitoring apparatus for observing health care cost trends, as will the Indiana Hospital Association data bank, and American Hospital Association Panel Survey.

Indiana Voluntary Effort

The objective is to bring the increase in health care costs more in line with the increase in the gross national product.

One of the nationwide goals is to reduce the rate of increase of hospital expenditures. Hospital costs in Indiana are currently about \$20 per day under the national average, due to voluntary budget review and rate approval. The Indiana Hospital Rate Review Committee, developed in cooperation with Blue Cross of Indiana in 1960, is considered a viable cost containment entity, since its purpose is to approve documented hospital rate increases based on anticipated expenses and revenues.

"Because Indiana hospitals have practiced voluntary cost control on a statewide basis longer than any other state in the nation, our budgets are perhaps leaner and we will have a more difficult time restraining costs further. We may have to plow new ground in cost containment, but we are certainly going to give it every try," said Mr. Kohr.

Dr. Goodman recognizes that physicians can play an essential part in the voluntary effort because they admit patients to hospitals, order their tests and treatment, and determine their length of stay. "I have dedicated my year as president of ISMA to attempting to solve this health care cost problem," he said. ISMA will be exploring ways to strengthen utilization review of hospital services, and to improving community health education, two recognized methods for reducing health care costs.

Others serving on the Task Force are:

Lloyd Banks, president, Indiana Blue Cross, Indianapolis; Edward Colby, manager, Indianapolis Operations, Detroit Diesel Allison Division, General Motors Corp., Indianapolis; Otto N. Frenzel, chairman of the board, Merchants



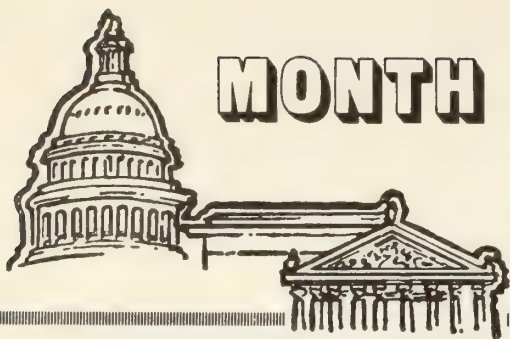
Discussing the Voluntary Effort are Herman J. Rutkowski (left), assistant vice-president of the Lincoln National Life Insurance Co.; Lloyd Banks (center), president of Indiana Blue Cross; and James A. Harshman, M.D., ISMA's president-elect.

PHOTOS BY INDIANA HOSPITAL ASSOCIATION

National Bank, Indianapolis; Don D. Hamachek, administrator, St. Francis Hospital Center, Beech Grove.

Also, Ian Rolland, president, Lincoln National Life Insurance Co., Fort Wayne; Dallas Sells, director of Region 3, United Auto Workers, Indianapolis; John Walls, president, Indiana State Chamber of Commerce, Indianapolis, and J. R. Zapapas, group vice president, Eli Lilly and Company, Indianapolis.

Others are James Harshman, M.D., ISMA president-elect, Kokomo; Richard Kilborn, president, Indiana Blue Shield, Indianapolis; Sister M. Martin, administrator, St. Joseph Hospital, Kokomo; Arthur Miller, Kokomo, president, Statewide Health Coordinating Council; Martin O'Neill, M.D., chairman, ISMA Board of Trustees, Valparaiso; Judy Palmer, executive assistant, Office of the Governor, Indianapolis, and William Paynter, M.D., State Health Commissioner, Indianapolis.



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

The Health, Education and Welfare Department has asked the Justice Department to delay granting the nation's hospitals an exemption under the antitrust laws to carry out their voluntary cost containment effort.

John Alexander McMahon, AHA president, said that "it seems strange that HEW would undermine and even try to undercut our Voluntary Effort" by taking this position before Justice.

HEW told Justice there may be "a serious lack of public accountability and public participation in the Voluntary Effort conducted by the AHA, the American Medical Association and the Federation of American Hospitals."

HEW General Counsel wrote Justice that the Voluntary Effort might discriminate against smaller community hospitals and health maintenance organizations and also might work to hold down wages of hospital workers.

HEW has been hostile to the Voluntary Effort from the outset, contending that only mandatory federal controls as embodied in the Administration hospital cost containment program are the answer to inflation in hospital costs.

Meanwhile, the war of words on the Administration's controversial hospital revenue control plan heightened when HEW Secretary Joseph Califano charged that opponents of the plan are "crowding the halls of Congress" and "lobbying for runaway inflation."

"Even Lloyds of London backed by the United States mint could not afford to insure the existing profligate, inflationary health care industry," he said in a speech.

The vote on hospital controls in the House Commerce Committee is considered the key to the fate of the Administration's plan. President Carter has dispatched a letter to every member of the Committee urging them to back the Administration's plan.

* * * * *



HEW is preparing to launch a program to encourage second opinions for surgery for Medicare/Medicaid patients. Patient pamphlets, physician enrollment, and radio-television ads ("second opinion—it's good for you") are projected.

"List-developers" will set up lists of physicians willing to participate in a second opinion (SO) program, on patient request. "List holders" will operate telephone referral centers to which patients may apply for the names of participating physicians.

Developers will query physicians as to their willingness to participate, inform them of any "ground rules," and develop the lists, with appropriate information such as willingness to accept Medicaid patients.

The Health Care Financing Administration of the HEW Department believes professional standards review organizations (PSROs) are the logical units to handle the "list" functions. However, carriers and medical societies also are eligible.

Public campaigns will begin soon and will consist of brief TV spot announcements and longer radio "dramas" on "SO" which will be distributed to stations. Five million leaflets will be distributed with Social Security checks in selected areas. A national "hot-line" (800 number) will be established, probably with the PSRO clearinghouse in Rockville, Md.

Once the program is operational, callers will be given the name of two or three physicians who are willing to accept requests for second opinion consultation. Wherever feasible, the referral center will try to give the names of physicians with some special competence in the type of condition for which surgery has been recommended, HEW said.

For Medicare patients, the program will pay for the second opinion as for other consultations, at 80 percent of the "reasonable charge," while Medicaid participation and payment, thus far, is at the option of the individual state. This may pose a tough problem in some states.

As presently planned, use of the "second opinion" will be at the patient's option, and the second opinion will not control payment for services.

The "SO" program is based on the assumption that second opinions will forestall unnecessary surgery.

* * * * *

In an unprecedented joint effort, Senator Edward Kennedy (D-Mass.) and the AMA will sponsor a 2½-day conference on "Positive Health Strategies" in Washington, D.C., July 25-27.

The sponsors have announced plans to bring together interested groups as cosponsors and participants to focus public attention on the potential benefits of

CONTINUED ON PAGE 654



ROCKWOOD

INSURANCE COMPANY OF INDIANA

Professional Liability Insurance Specialists

Physicians, Surgeons, Dentists

Hospital Professional Liability

Represented by:

Health Care Provider Insurance Agency, Incorporated

INDIANAPOLIS . . . Hadley-Mahoney Co., 3640 N. Washington Blvd. 46205
(317) 924-5331

MICHIGAN CITY . . Lindenmeyer Insurance Associates, Inc.
801 East Eleventh Street 46360
P.O. Drawer C
(219) 879-7301

SEYMOUR Wenco, Inc., Room 20, Vehslage Building
P.O. Box 518 47274
(812) 522-2931

SOUTH BEND . . . Hepler-Smith Insurance, Inc.
511 West Colfax Avenue
P.O. Box 1875 46634
(219) 232-4889 (Toll Free 1-800-552-2910)

MONTH IN WASHINGTON

CONTINUED FROM PAGE 652

strategies of disease prevention and to project possible programs for improvement in the 1980s.

The preliminary program lists keynote speakers as Sen. Kennedy, Tom E. Nesbitt, M.D., president-elect of the AMA, George Meany, president, AFL-CIO, and Lester Breslow, M.D., dean, School of Public Health, University of California, Los Angeles.

In an address before the AMA's Leadership Conference in January of this year, Senator Kennedy issued an invitation to the AMA to join him in sponsoring a national disease prevention conference designed to focus the attention of the nation on the great potential of preventive measures to reduce the toll of disease in our population.

Dr. Nesbitt, in accepting for the AMA, said, "We are happy to participate in an arena that encourages a wide spectrum of ideas and programs on health. Organized medicine and physicians have long been concerned with and active in the areas of disease prevention and positive health programs. We are certain that this interaction will be profitable to all Americans."

Meanwhile, Sen. Kennedy has launched a major new health initiative with introduction of legislation to instruct Americans on good health practices and disease prevention.

National health insurance can improve access to care, but it can't "make us a healthier and more long-lived people unless it is combined with a comprehensive strategy for reducing death and disability through prevention," Kennedy told the Senate.

The bill calls for spending \$150 million the first year, climbing to \$300 million. Existing health promotional activities would be expanded at the federal, state and local level and new ones installed.

Lowell Steen, M.D., of Indiana, a member of the AMA Board of Trustees, said the AMA is "basically supportive" of the measure, formally called the National Disease Prevention and Health Promotion Act of 1978. Dr. Steen told a national television audience that some of the programs are "things that the AMA has been advocating for many years." However, we have "some reservations" about certain provisions, Dr. Steen said.

Sen. Kennedy, appearing on the same program, said "I think we've got a good partnership," noting the jointly sponsored conference with the AMA in late July.

* * * * *

The Administration's \$500 million Health Maintenance Organization (HMO) bill ran into opposition from key senators alarmed over reports of widespread fraud and abuse.

"Wouldn't it be best to put brakes on the whole HMO program?" asked Sen. Herman Talmadge (D-Ga.), chairman of the Senate Finance Subcommittee on Health. Sen. Sam Nunn (D-Ga.), vice chairman of the Senate Permanent Subcommittee on Investigations, agreed. Sen. Carl Curtis (R-Nebr.) said that if HMOs are "any good, they will grow on their own" without the need for any federal subsidy.

Nunn told the Finance Subcommittee that "unless remedial action is taken, the federal government, through its program of financing the development of HMOs, faces the prospect of encountering nationwide the same kinds of scandal and abuse that have plagued the California Medicaid program." There is evidence that organized crime is moving into the HMO field, the Georgia senator warned.

The Investigations Subcommittee recently released a report charging large scale abuse and fraud in the California HMO program.

* * * * *

A "middle-of-the-road" national health insurance bill with powerful Senate backing has been introduced in Congress. Emphasis in the bill is placed on catastrophic coverage.

The measure is supported by Chairman Russell Long (D-La) of the Senate Finance Committee, Health Subcommittee Chairman Herman Talmadge (D-Ga.), and Sens. Abraham Ribicoff (D-Conn.) and Robert Dole (D-Kans.).

The bill is substantially the same as the one introduced in the 94th Congress by Long.

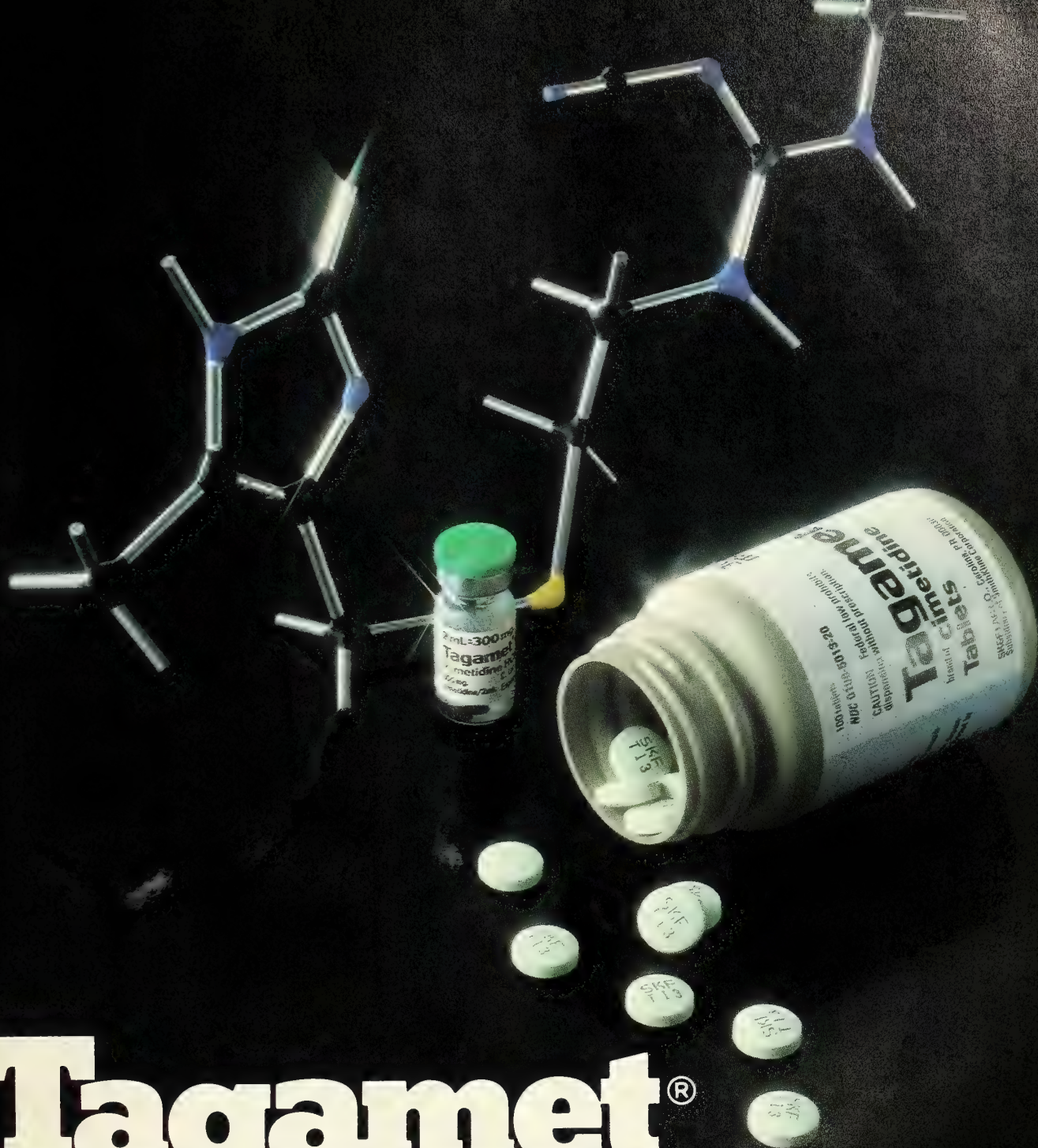
* * * * *

The White House Council on Wage and Price Stability plans an educational program for physicians on inflation in health care costs.

The Council also will seek the assistance of the AMA in developing an effective monitoring or reporting mechanism to measure the rate of physicians' fees with respect to an agreed upon "measuring device or indicator."

The objective is to develop a long-term mechanism to assist in cutting the rate of increase in the future.





Tagamet[®]

brand of

cimetidine

How Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only). Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
a SmithKline company

Important data on the pain of acute cystitis:

In 87% of patients studied (303 of 349), Azo Gantanol reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for
the pain

for
the pathogens

Before prescribing, please consult complete product information, a summary of which follows. **Indications:** In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Notes:** Fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. aminobenzoic acid to follow-up culture media increasing frequency of resistant organisms. the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood level variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatic uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergic bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria or stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypochromic anemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, nephrosis with oliguria and anuria, periarthritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, uretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused instances of goiter production, diuresis and glycosuria. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute painful phase of urinary tract infections. **Usual adult dosage:** 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) should be considered.

NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.



Roche Laboratories
Division of Hoffmann-La Roche
Nutley, New Jersey 07110

Time is the test of all things.



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon[®] Elixir
(potassium gluconate)
20 mEq per 15 ml

WARREN-TEED
LABORATORIES, INC.
DIVISION OF ADRIA LABORATORIES INC.
COLUMBUS, OHIO 43215



EMPIRIN[®] COMPOUND c CODEINE

Each tablet contains: aspirin, 227 mg; phenacetin, 162 mg; and caffeine, 32 mg; plus codeine phosphate in one of the following strengths: #4—60 mg (gr. 1); #3—30 mg (gr. ½); #2—15 mg (gr. ¼); and #1—7.5 mg (gr. ⅛). (Warning—may be habit forming).



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

An Important Message

For Reference Committee Members

The following remarks were made to members of this year's reference committees at an orientation meeting held at ISMA headquarters June 7. THE JOURNAL feels that these may be pertinent to ISMA's general membership in better understanding how policies of our organization are formulated.

Dr. (Lawrence E.) Allen, vice speaker, and I are most grateful for your willingness to serve on this year's Reference Committees. The issues considered by organized medicine today are too serious to be taken lightly. The burdens must be shared by far more of our membership than those considered to be the "hierarchy." If ISMA is to accurately reflect the views of our grass roots members, we must have a much broader input to arrive at a true consensus.

Dr. Goodman, Dr. Harshman and the Board of Trustees have conscientiously attempted to speak for us, as have their predecessors. But they can promote only the issues and policies formulated during the annual meeting of our House of Delegates. We can assure you that these physicians are acting well within the limits established by current House actions.

The various commissions and committees of ISMA meet faithfully throughout the year to study matters of vital concern to organized medicine, and therein lies much of the expertise from which many recommendations and resolutions arise that you will be considering. But we also must have input from county and district societies, sections and individual members in the form of resolutions in order to consider issues on the broadest possible basis.

Experience has shown that Reference Committee members are often unfamiliar with certain basis procedures, including Chapter 22, "Conventions and Their Committees," from *Rules of Parliamentary Procedure* by Sturgis. I therefore urge you to read this chapter.

Another past experience has been that Speakers have had to spend a lot of time editing Reference Committee reports. It is often difficult to do this without altering meaning or content. However, editing has sometimes been necessary to avoid confusion during the all-important, yet often lengthy, final session of the House during which

officers are elected, resolutions are voted upon and policies for the coming year are established. We hope that you will avail yourselves of the best possible advice as the resolutions are forwarded to you.

During your executive session you must formulate a report that is parliamentarily correct and clearly presents what you perceive to be the wisest recommendations to the House about how its members should vote. Dr. Allen and I would appreciate your expertise in this area so that we, along with many dedicated staff secretaries, will not have to stay up until the wee hours of the morning rewriting the reports, trying not to alter their general intent. We assure you that editing is done only with your final approval and authorization.

During Reference Committee hearings you are not expected to participate in debates. In fact, you are discouraged from doing so. You are there to hear testimony and debate by those in attendance, to see that *each* member desiring to speak is given ample opportunity to be fairly heard, and to maintain an orderly flow of discussion.

Guests are permitted to attend your meeting only with *your* prior approval and only for the duration of the discussion pertaining to their special interest. Please try to enforce this policy as diplomatically as possible.

Dr. Allen has suggested an innovative new Reference Committee for the sole purpose of providing more direct input into the policies of AMA by the general membership of ISMA. Matters of more exclusive national interest will be referred to this committee and the House will take action accordingly. The policies of the House will serve as mandates or recommendations to our AMA delegates. This should prove most helpful in giving our AMA delegates a broader base of Indiana membership opinion. Although this will require even more time to fit into an already crowded agenda, we are confident that well informed and parliamentarily wise Reference Committees will meet the final agenda expeditiously, efficiently and fairly.

Thank you.

LLOYD L. HILL, M.D.
Speaker, House of Delegates
Indiana State Medical Association

The Citizen's Power Is Being Undermined by Federal Action: Governor Bowen

(Indiana's Governor Otis R. Bowen, M.D., made the following remarks during the ISMA Fifth District annual dinner meeting in Terre Haute May 3.)

The purpose of my remarks this evening is one of sounding a warning—not so much a warning to my fellow physicians, for most of you are well versed in recent federal health initiatives. Rather, my warning is aimed at a far broader spectrum; and that is the public at large, and their elected state governments in particular.

The essential message of my warning is that the power of the individual citizen—as traditionally exercised through elected state and local officials—is being massively undermined by federal action; and further, that quite possibly health care may well be the issue that will ultimately determine whether state and local governments are to have any real significance, or whether they are to be nothing more than simply so many federal administrative units.

To me, the question boils down to one of the survival of state government. Are states to exercise any *real* sovereignty in the area of public health, or are they to be totally preempted by a federal government bent upon viewing the wants, wishes, needs and aspirations of Vigo County Hoosiers to be the same as Dade County Floridians, or Cook County Illini?

Let me tell *why* I believe public health could well be the pivotal issue in determining to be the shared responsibility of state, local and federal governments that has been our practice for more than two centuries.



One cannot argue that there are no problems connected in American health care. There *are* problems—and some are:

- Unequal, sometimes narrowly limited, access to health care—particularly in rural and some highly urbanized areas.
- Maldistribution, and possible shortages, of certain health professional and technical personnel.
- Rapid and disproportionate increases in health care costs.
- Uncoordinated and/or conflicting actions at different segments of the health care industry.
- Plus an entire range of particular problems that stem from all of those I just mentioned.

There is also a widely held belief that most of these problems could be solved by health planning that involves consumers with various kinds of expertise—as well as health professionals who possess varying backgrounds. So far as this line of logic goes, there is little about which one might dispute. However, let us trace a bit of history to see how the acceptance of this type of planning approach has been implemented by Congress and the Department of Health, Education and Welfare—and perhaps more important, how it has become a major issue of disagreement between the states and the federal government.

Modern federal attention to America's health care needs probably can be traced back to the enactment of the Hill-Burton program in 1946. In essence, Hill-Burton provided construction monies for needed new hospitals, and envisioned a state survey and planning process by which these funds could be doled out to meet unmet needs.

Hill-Burton has been much amended—in 1949, 1954, 1957, 1964, and again in 1970. Of these, perhaps the most dramatic amendments were those written in 1970, which authorized construction funds for neighborhood health centers, out-patient facilities in poverty areas, and alcoholic treatment centers—among others.

In 1973, Congress extended Hill-Burton for one more year, adding no new responsibilities, only sufficient dollars for another year of operations.

Concurrent to Hill-Burton's later years, came the enactment of Medicaid and Medicare in the mid-1960s, and the Comprehensive Health Planning (CHP) and Public Health Services Amendments of 1966. Combined, these two major efforts created the Regional Medical Program, and the Comprehensive Health Planning Program, which meant that the federal government was assisting states and localities in the operation of three distinct programs, with different histories and responsibilities—but with some overlap in their efforts in an overall goal of improving the health of the American people.

In 1967, the Partnership for Health Amendments modified the authority of these two programs, and in 1970 the Comprehensive Health Planning laws were twice amended. The primary effect of these 1970 amendments was to mandate the creation of a Health Planning Council for each area-wide agency, spelling out its membership, and requiring that each council have a consumer majority.

In 1972, the role of the CHP was further modified by providing that related Medicare and Medicaid expenditures would *not* be authorized in health care facilities deemed unneeded by the overall planning procedure.

In late 1972, and early '73, the Department of Health, Education and Welfare and the GAO both determined—through program au-

dit—that the CHP program had to be amended in several major ways. In essence, these modifications spelled out specific priority objectives that were to be carried out within each CHP—targeting primarily cost containment, minimizing duplication, and finding a more effective climate of “competition” from which the consumer could select.

While this CHP modification was going on, so too was the Regional Medical Program also undergoing similar redefinition and redirection.

It was at this point in history that the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) emerged.

Before 93-641 all of these older federal programs had a common denominator, and all were initially pointed in a laudable direction. In different ways, and at different points in time, all were directed to a problem-solving role, with a distinct goal of efficiency and economy.

Now, Public Law 93-641 partially consolidates the congressional interest expressed through these pre-existing programs, under one new comprehensive effort—one seeking to state and underscore 10 national priorities.

In highly distilled form, and dreadfully oversimplified, my impression of the 10 national priorities set by this law is that Congress sees the inter-related problems of distribution of facilities, services and health manpower—and that of cost containment—as being of the highest priority. Further, it intends to approach the resolution of these problems by a planning and resource development vehicle controlled by the Department of Health, Education and Welfare . . . fueled by federal health dollars . . . and free of actions by the public through their state or local government.

Within its tightly dovetailed 50 pages, 93-641 *does* envision a federal, state and local partnership. But that partnership is totally different from any we have known from more than 200 years of our national history. Rather than being a partnership among federal, state and local *governments*—all framed within appropriate constitutional bounds—this law sets up a partnership between a federal agency, and state and local quasi-public bureaus that are neither elected nor appointed in any fashion that assures accountability through election.

It was, and doubtlessly still is, viewed by DHEW as the primary mechanism through which a national health system—patronizingly misnamed “National Health Insurance”—is to be implemented.

This law requires the Secretary to publish “National Guidelines for Health Planning.” These proposed “guidelines” are broadly held to be national *standards* against which federal health dollars will be measured and doled out. What this all means is that all decisions about the type, quality, and amount of health care that will be available will be made wholly *outside* elected state and local government!

Few issues are capable of uniting all 50 of our nation’s governors. Opposition to 93-641 does just that! Further, that opposition flows from all areas of the geographic and political compass, but all find their base within the obnoxious nature of the process envisioned by Congress.

Despite what Congress or any federal agency thinks or decrees, we are a nation of *diverse* people. We are a nation of people with diverse interests who live in states, cities and towns that have equally diverse conditions, circumstances, resources and priorities. This condition ought not be considered either unusual or unacceptable by anyone who has even the *foggiest* notion of what a democracy is all about!

The first set of “guidelines” were originally published in the Federal Register Sept. 23, 1977. The Secretary of the Department of Health, Education and Welfare received an overwhelming number of responses from various congressmen, governors, administrators of state health agencies, local elected officials and representatives of numerous special interest groups.

On Jan. 18th of this year, HEW Secretary Califano published a revised set of proposed health “guidelines.” The 30-day comment period expired Feb. 20th, and the Department recently published its final “guidelines.” Our state experts are carefully reviewing them—but little in the way of favorable fundamental change may be expected.

Human care “cost containment” certainly has instant individual appeal to every man, woman and child in America. The massive institution of American health care makes an inviting target for the campaigning politician. It’s hard to be against claims of better health care at a cheaper price. Certainly that’s how Medicaid and Medicare were sold—and I doubt if even the massive failures within particularly the Medicaid program—and the over-

whelming cost of *both* to the taxpayer—will draw much mention from those waving the “cost containment” banner.

We are told that all we have to do is to wrest the control of these decisions from the hands of “inept” state-controlled systems, and “self-serving” health care providers—and put it all in the hands of DHEW and a handful of their local lackeys.

The irony of the entire process is that the decisions made under 93-641 will be touted as good examples of a free democracy, because decisions will be made by “local” HSA’s and “state” SHCC’s!

All I can say is that decisions of such a magnitude . . . decisions which affect so fundamentally the public health and welfare of Hoosiers, that are made by a method so far *beyond* the deliberate participation of properly constituted state and local government, serve to *deny* the citizens of Indiana the right to representation by a government of their own choosing on matters that directly and individually affect each and every one of them!

Yes, I believe that sound planning and implementation *has to* characterize America’s health care delivery system.

Certainly, tough managerial decisions have to be made so that costly and unnecessary duplication to health care facilities and personnel does not occur.

Truly, the overall cost of health care *has to* be held in reasonable line.

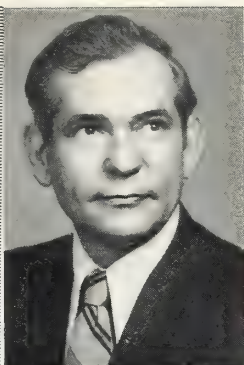
But let every American *clearly understand* what they will be giving up—to gain the supposed “benefits” of federal-controlled health care—will be the ability to act by or through officials they elect, and to whom they have access at their local level!

Let us understand that for the price of “cost containment,” all present and future health decisions will become the province of DHEW, and the system set in place by Congress. Let us further understand that once this system makes a decision, we will not be able to turn that decision around through any governor we elect, or through any state legislature we elect.

And *that*, my friends, is the message I bring—and the alarm I sound. It is not an issue of doctors protecting lucrative practices. It is an issue as fundamental to overall public policy-making in our nation as any that was debated in 1776—and resolved by the framers of our Constitution 11 years later.

This then, is the message that must be brought to, and understood *by*, every State Legislator and every citizen.

Thank you.



AS I SEE IT

Fred Smith, M.D.
Chairman of the Board
IMPAC



The purpose of this regular feature is to provide IMPAC board members an opportunity to express their views on the political issue of their choosing.

There has been much discussion by many IMPAC members about candidate support. Why did IMPAC support Congressman X instead of Congressman Y? Why does IMPAC not support more Democrats or more Republicans? Considerable research is done by staff and board members in arriving at a decision as to which candidate to support.

IMPAC supports candidates who:

- Support "free enterprise"
- Support Constitutional government
- Have a chance of winning

Let me elaborate on these criteria. If a Congressman or Senator favors and votes for bills that enhance the conduct of business with the least government interference, then he deserves IMPAC support. I submit to you that the private practice of medicine will be well protected if free enterprise flourishes. I think that we as physicians have, for too long, had tunnel vision and have been interested only in issues

that directly affect the practice of medicine without considering the entire free enterprise system.

Support of constitutional government involves interpreting the constitution in a literal manner rather than stretching it to accommodate changes in our daily lives that were never intended by the wise men who drafted it.

Can the candidate win? Will he work hard? Is he dedicated to winning? Does he have an organization or will he accept advice and allow others to build an organization? In other words, is his campaign built on a professional basis?

In applying these criteria, lip service is not accepted. Most incumbents will give assurances that they believe in these principles. But how did they vote? Their voting records in the Congress and Senate will reveal the true answer. This evaluation must not be confined to a vote on one bill but rather must consider the entire voting record of a given incumbent.

IMPAC is a bipartisan organization and has and will support Democrat or Republican candidates who meet these criteria.



McClain Car Leasing, Inc.

1745 Brown St., Anderson, Ind.

Phone 317/642-0261

Specializing in Professional Car Leasing

ALL MAKES AND MODELS AVAILABLE

We are proud to offer a Leasing Plan approved by ISMA

WHAT'S NEW?

CONTINUED FROM PAGE 639

Curity has a new, simplified, efficient and aseptic method for preparing hot, wet dressings. The Curity Wet Dressings System consists of a sealed package of wet dressings and a compact, portable heat lamp. The sealed dressings are placed in the lamp, heated for a few minutes and then aseptically applied to the patient. The dressings are available in either a sterile distilled water or sterile normal saline solution and come in two sizes, 8x4 inch, 32 ply or 18x8 inch, 8 ply.

* * *

Searle is introducing a new oral contraceptive in the United Kingdom that contains only 30 micrograms of estrogen. Called Conova 30, the new formulation also contains two milligrams of ethynodiol diacetate. Conova 30 has been well tolerated in clinical trials and Searle plans to introduce it worldwide.

* * *

IN BOOKS . . .

Doubleday has published "DAUGHTERS/From Infancy to Independence," a book for parents of girls. It was written by Stella Chess, M.D. and Jane Whitbread as a flexible guide on bringing up daughters. 265 pages—\$7.95.

* * *

Doubleday has released "The Male Mid-Life Crisis," by Nancy Mayer. Ms. Mayer is a writer in the mental health field. Her book discusses what happens to those men who begin to behave strangely around the age of forty—and what should be done about it. 288 pages—\$8.95.

* * *

The Simone Corporation has a new 16-page brochure that describes its unique construction/financing/management system for doctors' office buildings. The system includes feasibility studies, design, construction, parking and even doctor recruitment. This "no-cost" method of providing more comprehensive and more available health care is of benefit to the patient, the community, the doctor and the hospital.

* * *

"Cancer and the Worker" is a recent publication written to inform workers and plant managers about what is currently known (and what is not known) about cancer risks in the workplace. Copies may be obtained at a cost of \$2 from New York Academy of Sciences, 2 East 63rd St., New York City 10021.

* * *

Bobbs-Merrill has published a new textbook, "Orientation to Health Services." It is designed for a beginning course for students entering the field of health care. The author is Ruth M. Lee, chairman, Allied Health Division of Atlantic Community College. 141 pages—list price \$7.95, net price \$2.50.

* * *

Brief Summary of Prescribing Information Combined TEGOPEN^h (cloxacillin sodium)

Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL[®]

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



IN THE INDIANAPOLIS AREA, STAPH RESISTANCE HAS NOW REACHED 87%.*

*Resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER **TEGOPEN[®]** **(cloxacillin sodium)** „THE PENICILLIN OF TODAY”

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary
for prescribing information.



AUXILIARY REPORT

Ruth (Mrs. G. Beach) Gattman
President, ISMA Auxiliary

*Remember when hippie meant big in the hips,
And a trip involved travel in cars, planes and
ship?*

*When fix was a verb that meant mend or re-
pair,*

And be-in meant supply existing somewhere?

*When neat meant well-organized, tidy and
clean.*

*And grass was ground cover, normally
green?*

*When lights and not people were switched on
and off,*

*And the pill might have been what you took
for your cough?*

When fuzz was a substance that's fluffy, like

lint,

*And bread came from bakeries, not from the
mint?*

*When roll meant a bun, and rock was a stone,
And hang-up was something you did to a
phone?*

*When swinger was someone who swung in a
swing*

And pad was a soft, sort-of-chisony thing?

Words once so sensible, sober and serious

*Are making the freak scene like psychedelir-
ious.*

*It's groovy, man, groovy, but English it's not,
Me thinks that the language has gone straight
to pot!*

This poem was used as an introduction to her presentation on Communication at two area workshops by Mrs. Torrence P. B. Payne, AMA Auxiliary communications chairman. It emphasizes that what we say is not always what is heard. Mrs. Payne said, "Communication is a two-way situation. It is one of informing, but also one of listening." In her stimulating and informative talk she pointed out that the newsletter is the glue that binds auxiliary together. It is one of our best communication tools. She reminded us that to be clearly understood frequently demands repetition. Commenting on the AMA's Immunization Awareness Program, she encouraged us to become involved on the county level, provided we have the approval of the county medical society. Each of us who heard her benefitted from her excellent presentation.

Better communication was the emphasis of all three area workshops, held in Plymouth, Brown

County and Indianapolis. Our goal was to provide information, stimulate interest and involvement in auxiliary projects and programs, and provide interaction, in a smaller group, with county and state auxiliary leadership. That our workshops were successful was indicated by the positive comments made by the 125 auxiliary members who attended and requested that these workshops be held again next year. My thanks to Carol Benson, Bonnie Meyer and Marianna Irwin, our area vice-presidents, who were responsible for planning and executing each workshop.

On behalf of the Auxiliary may I say thank you for giving us the opportunity to communicate each month with the ISMA through The Journal. We're proud to be a member of the Indiana medical team. If we can assist you in any manner, just ask.

contains no aspirin

tablets

Darvocet-N[®] 100 (IV)

100 mg. Darvon-N[®] (propoxyphene napsylate)
650 mg. acetaminophen



700565

*Additional information available
to the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46206*

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

*"In a real dark night of the soul
it is always three o'clock in the morning."*

—F. SCOTT FITZGERALD
THE CRACKUP, 1936



Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime! Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

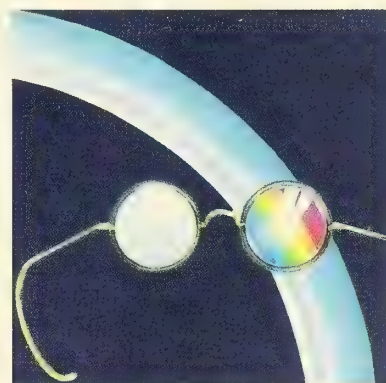
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.







When they see life
in shades of blue...
help them see life
in all its colors.

Adapin®

(doxepin HCl)

single daily dose recommended h.s.

-  10 mg capsules
-  25 mg capsules
-  50 mg capsules
-  NEW 100 mg capsules

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

The AMA Computer Systems in Medicine Consultative Services Program



The American Medical Association recognizes the potential that computers have in the health care setting. Therefore, the AMA has initiated the **Computer Systems in Medicine Consultative Services Program**. Through this program, physicians who are considering computer services as well as current users who want to improve or expand their computer applications can obtain an objective viewpoint and expertise in methods and equipment.

Computers have the potential to be a tremendous asset to the medical community, and have possible application in some or all of the following:

- Improving patient care
- Creating more accessible medical records
- Improving financial management and control
- Reducing the rate of increasing costs
- Improving facility and personnel utilization

The **Consultative Services Program** has established expertise extending from general decision-making on the utilization of computers in medicine to detailed systems design, programming and implementation of systems. The Program's activities include: needs analysis; alternatives development; specifications

development; proposal evaluation; and systems audits.

While the major thrust of the **Consultative Services Program** will result from interest in the use of computers or computer-related services, the primary goal of the consultant is to recommend the most advantageous treatment of each situation. **The focus is the needs and objectives of the client**, not the promotion of computerized solutions.

For a more detailed description of this new and valuable service or to arrange a consultative visit, contact: John A. Guerrieri, Jr., Program Director, Consultative Services Program, at (312) 751-6417.



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article continues my discussion of the gift and estate tax sections of the Tax Reform Act of 1976 (TRA) and the proposed changes which are in the Technical Corrections Bill (TCA).

As stated in my article of last month, the basic steps in computing the estate tax marital deduction after the TRA are as follows.

1. First, determine the net value of the property which is eligible for the estate tax marital deduction. In no case may the estate tax marital deduction exceed this amount.

2. Second, determine the greater of: \$250,000; and, 50% of the decedent's adjusted gross estate.

3. Third, as discussed below, determine the reduction of the maximum estate tax marital deduction (as determined in Step 2, above) which reduction is required because of certain gift tax marital deductions which the decedent deducted during the decedent's life.

4. Fourth, reduce the greater of the two maximum estate tax marital deduction limitations (as determined in step 2, above) by the reduction (as determined in step 3, above). In no case, may the estate tax marital deduction exceed the reduced amount of the greater of the two maximum estate tax marital deduction limitations.

The following simple examples should illustrate typical computations of the new estate tax marital deduction. These examples do not illustrate any computation problems which are not unique to the new law, nor do the examples involve the reduction of the maximum estate tax marital deduction because of uses of the gift tax marital deduction. This reduction is discussed below.

Example One. Assume that a decedent died after 1976 with an adjusted gross estate of \$100,000 and that the decedent devised a net value of \$30,000 (of property which qualified for the estate tax marital deduction) to the decedent's spouse. In this case, the decedent's estate tax marital deduction is limited to the lesser of: \$30,000; and, the greater of \$250,000, and, 50% of \$100,000 (\$50,000). Thus, the decedent's estate tax marital deduction is \$30,000.

Example Two. Assume that a decedent died after 1976 with an adjusted gross estate of \$100,000 and that the decedent devised the decedent's entire estate to the decedent's spouse, all of the property of which qualified for the estate tax marital deduction. In this case, the decedent's estate tax marital deduction is limited to the lesser of: \$100,000; and, the greater of \$250,000, and, 50% of \$100,000 (\$50,000). Thus, the decedent's estate tax marital deduction is \$100,000.

Example Three. Assume that a decedent died after 1976 with an adjusted gross estate of \$300,000, and that the decedent devised the decedent's entire estate to the decedent's spouse, all of the property of which qualified for the estate tax marital deduction. In this case, the decedent's estate tax marital deduction is limited to the lesser of: \$300,000; and, the greater of \$250,000, and, 50% of \$300,000 (\$150,000). Thus, the decedent's estate tax marital deduction is \$250,000.

Example Four. Assume that a decedent died after 1976 with an adjusted gross estate of \$500,000 and that the decedent devised the decedent's entire estate to the decedent's spouse, all of the property of which qualified for the estate tax marital deduction. In this case, the decedent's estate tax marital deduction is limited to the lesser of: \$500,000; and, the greater of \$250,000, and, 50%

of \$500,000 (\$250,000). Thus, the decedent's estate tax marital deduction is \$250,000.

Example Five. Assume that a decedent died after 1976 with an adjusted gross estate of \$800,000 and that the decedent devised the decedent's entire estate to the decedent's spouse, all of the property of which qualified for the estate tax marital deduction. In this case, the decedent's estate tax marital deduction is limited to the lesser of: \$800,000; and, the greater of \$250,000, and, 50% of \$800,000 (\$400,000). Thus, the decedent's estate tax marital deduction is \$400,000.

This new alternative maximum limitation on the estate tax marital deduction is as radical a change to the estate tax as the change in the limitation to the gift tax marital deduction, and, as a consequence, tax planners will have to completely re-think the principles which are generally considered when estate planning problems are presented. Further, as clients become aware of the new law, many of the clients are going to pressure tax planners into returning to simpler estate plans in which each spouse agrees to transfer, upon the death of one spouse, all of their property to the surviving spouse, and then, upon the death of the second spouse, the remaining property will pass to, for example, the spouses' children. That is, because spouses may now transfer a minimum (and perhaps maximum) amount of \$250,000, estate tax-free, many spouses, who do not have large estates, are going to choose to eliminate the complex Trust A-Trust B estate tax marital deduction arrangement (which they do not fully understand anyway). This is not to say, of course, that such a decision will be a wise one.

On the other side of the coin, there are many lawyers who will think it will not be necessary to amend the wills and trust agreements of their clients, because the lawyers drafted estate tax marital deduction clauses for the clients which clauses devised the "maximum estate." That is, some lawyers will assume that the "maximum marital clauses which devised "one-half of the decedent's adjusted gross estate." That is, some lawyers will assume that the "maximum marital deduction clauses" are self-adjusted to the new law. However, in general, this is not the case.

That is, section 2002 of the TRA provides that if a decedent dies after 1976 and before 1979, and if the decedent's will or trust agreement was executed prior to 1977, and if such will or trust agreement contains an estate tax marital deduction clause which devises to the decedent's spouse the maximum amount of property which qualifies for the estate tax marital deduction, and if such formula clause is not amended after 1976 and before the death of the decedent, and if the state (the laws of which govern the probate of the decedent's estate) does not enact a statute which construes this type of formula clause as referring to the new maximum estate tax marital deduction limitations, then such new maximum limitations are not applicable to such a decedent's will or trust agreement, as the case may be. That is, such an individual will be allowed as estate tax marital deduction which is based upon prior law—that is, the law which was in existence prior to the TRA. However, if such an individual wants to utilize the new estate tax marital deduction limits, then the individual must amend his or her formula clause in order to make it clear that the individual wants to devise an amount to the

CONTINUED ON NEXT PAGE

TAX TIPS

CONTINUED FROM PAGE 671

decendent's surviving spouse, which amount will be the maximum amount which will qualify for the estate tax marital deduction under the new law. In fact, if an individual amended the individual's formula clause during 1976, and specifically referred to the maximum estate tax marital deduction which is available under the TRA, then such a clause is not subject to the 1977 and 1978 transitional rule. That is, such an amended clause will pass the greater of: \$250,000; and, 50% of the adjusted gross estate. I.R.S. News Release, IR-1706, 12/3/76. On the other hand, if an individual who executed such will or trust agreement, prior to 1976, does not amend the clause, and dies after 1979, then such individual's will or trust agreement will be construed, for federal estate tax purposes, to include the new limitations.

Perhaps, these latter points might be clearer if I summarize the basic situations which can arise concerning wills and trust agreements which were drafted prior to 1977 and which contain the "maximum estate tax marital deduction clauses."

First, if such a clause is not amended in order to make it clear that the decedent intended to devise the decedent's surviving spouse the maximum amount which is allowable under the new law, and if the decedent dies after 1976 and before 1979 (namely, within a two-year period of time), then the decedent's estate tax marital deduction will be limited to the amount which was allowable under the pre-1977 law, namely, to a maximum amount of 50% of the decedent's adjusted gross estate.

On the other hand, if such an individual (who does not so amend) dies after 1978, then the decedent will be entitled to an estate tax marital deduction which is based upon the TRA's maximum estate tax marital deduction of the greater of: \$20,000; and, 50% of the de-

cedent's adjusted gross estate. Similarly, if such an individual does properly amend the individual's "maximum estate tax marital deduction clause," then the individual will be entitled to the new maximum estate tax marital deduction—no matter when the individual dies.

Further, if an individual executed a will or trust agreement prior to 1977, which will or trust agreement contained the "one-half of the decedent's adjusted gross estate marital deduction clause," then such an individual will be entitled to an estate tax marital deduction which is based upon 50% of the decedent's adjusted gross estate, and not upon the alternative \$250,000 amount. And, this will be true regardless of when the individual dies.

Thus, it is apparent, that the principal type of individual who may lose by not amending his or her will or trust agreement (insofar as this discussion is concerned) is the individual who dies with an adjusted gross estate of under \$500,000. That is, if such an individual has the unamended pre-1977 maximum estate tax marital deduction clause, then the individual will not benefit from the new base estate tax marital deduction of \$250,000, and, will be entitled to an estate tax marital deduction of only 50% of the individual's adjusted gross estate. Similarly, if an individual with an adjusted gross estate of under \$500,000, dies with the "one-half of the adjusted gross estate marital deduction clause," then, obviously, such an individual will be entitled to an estate tax marital deduction which is based upon 50% of the decedent's adjusted gross estate—and not be entitled to the new base estate tax marital deduction of \$250,000.

Therefore, an individual who has a "small" estate should be the first person who should consult with his or her lawyer as to whether it would be advantageous for such an individual to amend his or her will or trust agreement. Further, as a practical matter, most individuals would be wise to consult their lawyers about amending such individuals' wills and trust agreements in order to determine whether their specific wishes (including, in this regard, their wishes as to death tax savings) are going to be carried out by the provisions of their present wills and trust agreements.

One final point concerning the effective dates of the new maximum estate tax marital deduction provisions concerns the validity of the effective dates of these provisions. As I stated above, it will not be too long before lawyers challenge the validity of section 2035, and, hard on the heels of that challenge, will be a challenge to these effective dates. Undoubtedly, most of these challenges will occur in situations in which a probate court determines that a decedent (who executed a "pre-1977 maximum estate tax marital deduction clause") actually intended to devise the maximum amount allowable—after considering all future changes in the federal estate tax law—and thus, the probate court allows a transfer to Trust A (the estate tax marital deduction trust) based upon the new maximum estate tax marital deduction provisions. Because the Internal Revenue Service will deny, in such a case, an estate tax marital deduction which is based upon the larger amount, the probate court will have to "stretch" such a decedent's intent in order to include an amount which may not, in fact, be deductible for estate tax purposes. On the other hand, Congress' position (for denying the new greater estate tax marital deduction to such a decedent) is clearly based upon the intent which Congress has automatically ascribed to the decedent. Thus, a question will undoubtedly be raised as to whether this ascribed intent should govern in a situation in which the decedent's intent was clearly otherwise.

If you would like a copy of my complete discussion of the major gift and estate provisions of the TRA and the TCA, you may obtain one (along with several other articles concerning the TRA) by writing: R&R Newkirk, Legal Department, Post Office Box 1727, Indianapolis, Indiana 46206.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Indiana State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and
models including Mercedes, Jaguar,
Porche, BMW, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition we want to lease
you any professional equipment that can be de-
preciated.

Immke Circle Leasing Inc.
32 South Fifth Street
Columbus, Ohio 43215

Call Collect
Telephone 614-228-1701 or
317-472-3594

From The Journal 50 Years Ago

An End to Night Life

WHILE discussing the subject of asexualization at a medical meeting, a prominent woman physician told the following story:

A tomcat owned by two solicitous old maids had a habit of going to the door at about 9 o'clock each night and scratching as an indication that he wanted to get out. Once outside of the house that was the last seen of him until the following day when he returned somewhat battered up and having a dejected appearance, but after sleeping quietly in an armchair or in the lap of one of the old maids throughout the day he exhibited the usual desire to get out at 9 P.M. and would spend another night of dissipation only to return the following day with the usual earmarks.

Some friend advised the old maids that a veterinary surgeon could perform a simple operation on the tomcat and forever afterwards he would stay at home and be content with the

humdrum life of his comfortable home. Therefore, being assured by the veterinarian that he could fix the tomcat so that night life would have no attractions for his feline majesty, the operation was performed, and after a few days' confinement in the cat hospital Tom was returned to his old maid owners.

However, at 9 P.M. on the first night following his return from the hospital, Tom scratched at the door, was let out as usual, and just as usual failed to return until the following day when he was found to be as battered up as ever. In great alarm the old maids called the veterinarian and told him that Tom had not been cured.

The veterinarian replied that they would have no further trouble, but upon being asked why Tom should have gone out the first night after the operation the veterinarian replied, "Oh, he was just out cancelling his dates and now he will stay at home."

JISMA, July 1928

Rural Community Physicians

THE National Grange is attempting to solve the question of how to give medical service to rural communities and is asking for the co-operation of the American Medical Association. We believe that the solution of this question, as mentioned before in the columns of this journal, lies in an effort on the part of people residing in rural communities to pay a physician decent remuneration for remaining in their community.

Too often the physician in the rural community is used in emergency only, and the people of the community chase off to a nearby city for much attention that could be given equally as well at home. We are not unmindful of an argument we often have made that a physician who renders good service will have no difficulty in obtaining patronage, but we realize that the general tendency on the part of people in the rural communities is to overlook the man right at home in the mistaken belief that something better may be obtained farther away, and thus much time is lost

to the rural physician in gaining that prestige and especially the income that is his due.

We are not in favor of offering salaries for rural service, though it could be arranged whereby the income from practice could be increased through an honorarium as local health officer, and the community as a whole could guarantee that the physician in the community would have a reasonable income from practice. In reality the practice of medicine is a business, insofar as it offers an avenue for the support of the physician and his family, and no physician willingly will begin or continue practice in a rural community when he cannot make a decent living there for himself and family, and that is the problem that must be solved.

Find some way to make rural practice more remunerative and there will be no trouble about getting physicians to fill places in rural communities.

JISMA, July 1928

ISMA ANNUAL MEETING

October 22-25 • Clarksville

From Jasper to Africa

Dr. Charles H. Klamer, Jasper physician and surgeon, returned last December from a month-long mercy mission to Zaire, Africa, where he gave medical care, dispensed medicine and performed operations at the Wembo Nyama Hospital and in villages as far as 300 miles from the hospital.

Dr. Klamer volunteered his services at the request of the Rev. Ralph I. Alton, Methodist bishop of Indiana. "United Methodists of Indiana have assumed a major share of support for medical work in Africa that is now in a state of transition," pointed out Bishop Alton in a brochure that appeals to doctors to help upgrade and reorient medical programs that originated through earlier mission efforts. "Indiana surgeons are needed who will each volunteer to spend at least four weeks working at the Wembo Nyama Hospital in Zaire. The immediate need is for general practitioners who can perform surgery . . ."

While Dr. Klamer and his wife, Cecile, had been in Africa seven times before on their frequent world travels, this marked the first time that he practiced his profession on the Dark Continent. This was no vacation trip, and before his month's stay was over he had lost 20 pounds. Mission workers generously shared their meals, although at times supplies were meager. The sandy soil is not very productive.

Dr. Klamer said his stay in Africa was fraught with hazards and the conditions under which he worked were sometimes indescribable. When he operated, the surgery light was energized by a small generator. Water had to be carried from a nearby river. There is no electricity and very little kerosene or gasoline. The hospital has no kitchen or food supplies. The patient's family provides the food.

While the local physician took with him about \$20,000 worth of drugs and medicines donated by drug firms, he encountered some diseases that American doctors don't normally have to treat,

such as elephantitis, leprosy and malaria. "Nearly everybody has worms," said Dr. Klamer, "and the prevalence of sleeping sickness, which is spread by the tsetse fly, is awful."

The worst disease is kwashiorkor, caused by protein deficiency. It is especially prevalent in children. Diseases kill about half of the children before they reach the age of 5.

Some of the natives he treated in the African bush had not seen a doctor in six months. The people are all very poor and live from day to day. However, said Dr. Klamer, they were very friendly toward him for the most part despite the fact that there is much unrest in Africa and much ill will toward the United States.

There was one occasion when the natives weren't friendly. A man who had been brought into the hospital lived for only a matter of hours. A mob of about 300 persons formed outside the hospital and demanded to see the white doctor who had killed their relative and friend. When Dr. Klamer, who had just returned from an outpost 300 kilometers away, convinced them that he had not even seen the patient, much less treated him, they blamed the native witch doctor for his death and demanded to see her. In the past, some witch doctors and also a white doctor had been killed by mobs whose members believed that deaths had been due to ineptness or deliberate design.

Dr. Klamer, to spare the witch doctor from possible injury or death, performed an outdoor autopsy on the dead man and allowed the angry villagers to see his diseased internal organs. He had died of hemorrhaging induced by cirrhosis of the liver.

Reprinted with permission of THE DUBOIS COUNTY HERALD. The original article was written by S. E. Stemle, former city editor of that newspaper. The story was published in December 1977.

In Zaire diseases kill about half of the children before they reach the age of 5.

. . . and Back

Dr. Charles H. Klamer



The local physician said he arose at daybreak to the sound of tom toms and worked until dark, when everybody in the village retires because there are no electric lights and even candles and kerosene are in short supply.

His first work when he arrived at the hospital was to open the surgery department. There were only a few patients in the facility at that time and there had been no surgeon available for months. Dr. Klamer performed many tumor and hernia operations. The most extensive bleeding he has ever seen in his medical career occurred when he amputated the greatly enlarged leg of a man who was afflicted with elephantitis.

Dr. Klamer had to take a crash course in linguistics and learn enough of the native language to carry on a limited conversation. The natives gave him a new name—Watshi (Chief) Uwandji (Doctor) Wangasano (Very Active Man).

The Jasper physician was flown on his trips to outlying areas by a well-known bush pilot, Fay Smith, a native of Springfield, Ill.

While Dr. Klamer likes animals, he did not see many of the animals that are native to the area and they were no threat as he rode a bicycle the six blocks from the Methodist mission to the hospital during the daylight hours. However, one night just before he went into the area to work, a lion killed three of the goats that were kept on a platform six feet above the ground near his place of residence. On another occasion some ele-

phants demolished a nearby hut. The natives killed three of the ponderous intruders the next day and were butchering them as Dr. Klamer arrived by plane to work. Fresh elephant hide is regarded as a delicacy by the natives, who boil it for three days.

One of the mementoes Dr. Klamer brought back with him is a 30-foot python skin that was presented to him one day in a village ceremony. Two men stretched out the skin of the giant snake to its full length after which it was explained that the straight python skin represented the straight road by which Dr. Klamer had come to the village and by which the natives hoped he would some day return. Then they rolled it up, tied it with braided rope and presented it to him.

Many of Dr. Klamer's experiences and impressions are preserved on magnetic tapes that he recorded in Africa. One of them contains an appeal to other doctors regardless of religious affiliation to devote a month's time to service in the darkest part of Africa "where people are dying daily for lack of medical attention. They cry, they hurt, just as you and I. I am not a particularly religious man but I have tried all my life to help people and I appeal to my colleagues to spend a month in Zaire. You won't find some of the places on the map and you will have to pay your own way but the experiences you will have will be some of the most worthwhile of your entire lives."

ANCEF[®] IV IM
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)

**For serious
respiratory infections**

due to susceptible indicated organisms



Bactericidal *in vitro* against susceptible strains*

IV/IM Dosage Flexibility

'Ancef' may be given either IM or IV at the same dosage schedule.

Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in PDR or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae*, *Klebsiella* species, *Hemophilus influenzae*, *Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli*, *Proteus mirabilis*, *Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus*.

Septicemia due to *Str. pneumoniae*, *S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis*, *E. coli*, and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES

SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocytopenia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

Smith Kline & French Laboratories
Philadelphia, Pa.

ANCEF[®] IV/IM
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

SK&F
a SmithKline company

THE JOURNAL, in cooperation with the Division of Postgraduate and Continuing Medical Education of the Indiana University School of Medicine, offers its readers a Continuing Medical Education program. This is the sixth in a series of articles written for purposes of continuing medical education—produced by the faculty of the School of Medicine and supported by a grant from its

Division of Postgraduate and Continuing Medical Education.

Through reading and following each article carefully and answering the Quiz correctly, one hour of Category 1 AMA Continuing Medical Education credit is offered for the reader's application for the Physician's Recognition Award of the American Medical Association.

Details and quiz on Page 699.



The Causes and Medical Treatment of Urinary Calculi

ABSTRACT

The patient with renal calculi requires a careful history, physical examination, urinalysis, intravenous urogram, and measurements of calcium and uric acid in serum and urine. The urine should be strained, and recovered stones should be submitted for chemical analysis. If a definitive cause for stone formation is found, prevention and control are generally successful; however, in the majority of cases no specific abnormalities responsible for stone formation are detected. In these patients, the cornerstones of treatment remain the detection of obstruction and infection, and the maintenance of a high urinary flow rate.

RICHARD BLOCH, M.D.*

Lafayette

FRIEDRICH C. LUFT, M.D.

Indianapolis

Renal stones have dogged man and his physicians since antiquity. Hippocrates exhorted his followers: "Neither will I cut them that have a stone, but leave this operation to those who are accustomed to perform it." Since stones account for 1.9 to 19.2 annual hospital admissions per 10,000 population,¹ stones concern not only "those who

are accustomed to perform . . ." their removal, but also physicians engaged in nonurologic specialties. A classification of stone disease based on etiology appears in the accompanying *Table*.

INITIAL APPROACH

When a patient with renal calculi is encountered, specific historical points of importance should be sought: the amount of fluid intake, food preferences, intake of preparations rich in calcium (i.e., milk products), or oxalate (tea, chocolate, cocoa, rhubarb, beans, broccoli, beet roots, spinach), as well as vitamin D, analgesics, antacids and other drugs.

Following examination of the patient, the urine should be examined for typical crystals and evidence of infection. A urine culture should be obtained. Since 90% of calculi are radio-opaque, they are frequently identified on plain films of the abdomen. Uric acid stones are radio-lucent; however, cystine stones are radio-opaque by virtue of their high sulphur content.

Intravenous urography is extremely helpful in diagnosing and may even be therapeutic because of the considerable osmotic diuresis that accompanies the procedure. In addition to the complete blood count and tests of renal function, serum electrolytes, uric acid, calci-

*Dr. Bloch is presently associated with the Arnett Clinic, Lafayette.

From the Renal Section, Department of Medicine, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

um, and phosphorus should be obtained.

One or more 24-hour urine collections should be collected for the measurement of creatinine clearance, calcium and uric acid excretion. The 24-hour urine calcium excretion on a regular (~1,000 mg/day) diet is less than 250 mg/24 hrs. On a low calcium (~400 mg/day) diet, the value should be less than 150 mg/24 hrs. The 24-hour uric acid excretion should be less than 600 mg/24 hrs. In children and juveniles, the urinary excretion of cystine may be helpful. Rarely, a 24-hour excretion of oxalate may be necessary. During acute episodes, the patient should be instructed to void into a cheese cloth covered container, thereby straining the urine. If a stone is recovered, it should be submitted for clinical analysis. In Indiana, the stone may be submitted to: Beck Analytical Service, P.O. Box 1057, Bloomington 47401.

PHYSICO-CHEMICAL ASPECTS OF STONE FORMATION

The formation of renal calculi, whatever the underlying disorder, is strictly a physico-chemical phenomenon. Three major theories of stone formation and growth have been proposed. The matrix-nucleation theory is based on the assumption that some initiating matrix substance, probably a urinary mucoprotein, forms a nidus for subsequent stone growth on the renal papilla.² Although nuclei of urinary mucoprotein are often found within stones, the theory fails to explain the lack of stone formation in non-stone formers who also excrete mucoprotein.³ The definitive role of this material in stone initiation remains unclear.

The supersaturation of urinary colloids may eventually lead to precipitation of crystals and stone formation. This has been shown in cases of stones secondary to the

excess excretion of cystine, xanthine, and uric acid. In these diseases, the urine is clearly supersaturated with the constituent responsible for stone formation. This theory is more difficult to apply in patients forming stones composed primarily of calcium and oxalate. In these individuals, the excretion of the responsible constituent may be well within normal limits, and the urine may not be supersaturated.

The absence of an inhibitor to crystallization has been proposed as responsible for stone formation in some individuals. The function of such inhibitors is to stabilize, and hold in solution, larger amounts of crystalloids than would be possible in a simple aqueous solution. Several inhibitors have been identified *in vitro*, namely small polypeptides, pyrophosphates, magnesium and citrate. Nevertheless, in man, stone formation has not been exclusively attributed to the absence of an inhibitor.

Despite numerous studies, no single factor or single mechanism successfully explains more than a limited number of stone forming episodes.⁴ Therefore, physicians must usually resort to general principles and non-specific therapy to control stone formation.

MANAGEMENT

General

The mainstay of therapy for renal calculi is a high fluid intake. At least three liters of urine should be excreted per day. Diuresis at night is particularly important, and may be accomplished by encouraging the patient to drink 12 ounces of water at bed time, to be repeated upon arising at night to void. Infection must be promptly diagnosed and treated. If eradication cannot be successfully achieved, stone removal may be necessary. Frequent surveillance by means of culture and sensitivity is indicated.

Specific

Calcium stones account for 80% of cases. They usually consist of calcium oxalate, calcium phosphate, or both. If the urinary calcium ex-

TABLE

Causes of Renal Calculi	Type of Stone	Frequency (%)
Enzyme Disorder		
Primary hyperoxaluria	Calcium oxalate	0-1
Xanthinuria	Xanthine	
Stones Associated with	Calcium oxalate	1
Malabsorption Diseases		
Jejuno-ileal bypass		
Inflammatory bowel disease		
Infection and Renal Stones	Calcium magnesium ammonium phosphate	1-10
Cystinuria	Cystine	1-3
Renal Tubular Syndromes		
Distal Type	Calcium phosphate	4-20
Proximal Type		
Uric Acid Stones	Uric Acid	1-10
Gout		
Increased purine metabolism		
Hyperparathyroidism		
Idiopathic stones		
Hypercalcemic Disorders	Calcium phosphate/oxalate	3-10
Hyperparathyroidism		
Sarcoidosis		
Vitamin D overdosage		
Idiopathic Hypercalciuria	Calcium phosphate/oxalate	40-50

cretion is high (>250 mg/24 hrs), the following disorders should be considered (Table): high calcium intake, corticosteroid therapy, immobilization, renal tubular disorders, hyperparathyroidism, and idiopathic hypercalciuria. History, serum electrolytes, and serum calcium values will identify all but idiopathic hypercalciuria. This disorder may be caused by either inappropriate gastrointestinal absorption of calcium or inappropriate renal excretion. A low calcium diet may be helpful, but is frequently inadequate. In Indiana, the water is often exceedingly "hard" and may indeed contribute to stone disorders.

Thiazide diuretics serve to decrease urinary calcium by promoting increased proximal tubular reabsorption of calcium.⁴ They are only effective if the dietary sodium is also limited. A 500 mg daily dose of chlorothiazide (Diuril®) is usually sufficient. Cellulose phosphate has been used to lower urinary calcium. This material is not absorbed, but forms insoluble complexes with calcium in the gastrointestinal tract.

If the urinary calcium is normal, neutral sodium phosphate (Nutra-phos®) may decrease the episodes of stone formation by increasing urinary pyrophosphate excretion. Pyrophosphate is purported to be an inhibitor of crystallization. The dose should not exceed 1 gm elemental phosphate daily since higher doses have promoted metastatic calcifications.⁵ Some individuals with recurrent calcium calculi also have high serum uric acid concentrations or relatively high urinary values. In these persons allopurinol (Xyloprim®) may reduce the episodes of stone formation.

Recurrent calcium oxalate stones may be seen in individuals with hyperoxaluria. The primary form is a rare inborn error of metabolism that need not concern us further. Secondary hyperoxaluria may be seen in malabsorption states. These conditions are characterized by excessive oxalate absorption. A common example is the stone formation observed in patients who have un-

dergone intestinal bypass operations. A low oxalate diet may reduce the hyperoxaluria.

Uric Acid Stones. Factors promoting the development of uric acid calculi are a low urinary pH, and/or an elevated uric acid excretion. The former is commonly observed in normal elderly patients, patients with chronic diarrhea who have a persistent gastrointestinal loss of alkali, and gouty individuals who commonly excrete a highly acid urine for reasons not well understood. About 30% of gouty subjects and individuals suffering from certain hematologic malignancies may excrete increased amounts of uric acid, particularly after treatment with cytotoxic drugs. The solubility of uric acid is increased 100-fold by raising the urine pH from 5.3 to 6.5. Therefore, alkalization of the urine is highly desirable. Sodium bicarbonate tablets are helpful to this end. Intermittent acetazolamide (Diamox®) may be a helpful supplement, particularly at night. The uric acid production, and hence its excretion, may be decreased with allopurinol (Xyloprim®) 200-600 mg/day.

Cystine Stones. Cystinuria accounts for approximately 3% of renal calculi and comes to mind primarily when one encounters stone disease in children and young people. High fluid intake, alkalization of the urine and D-penicillamine are the available therapeutic measures; however, the disorder is exceedingly difficult to manage.

Infection. Stones associated with infection are almost always related to the presence of urea-splitting microorganisms such as *Proteus sp.* These stones are generally composed of calcium, magnesium and ammonium phosphate. They may rapidly increase in size. Surgical removal is frequently necessary to clear the urinary tract of infection.

SUMMARY-CONCLUSION

A minority of individuals suffering from renal calculi have specifically treatable, underlying disorders such as hyperparathyroidism. The

majority have recurrent calculi for unknown reasons, of which calcium stones are the most common. A high fluid intake, control of infection, and relief of obstruction are important aspects of management. Patients with calcium stones may require a decrease in calcium intake, or a thiazide diuretic if the urinary calcium excretion is high. Neutral sodium phosphate may be helpful. Occasionally, a high oxalate intake or the hyperoxaluria observed in malabsorption states are responsible for stone formation. Uric acid stone formers benefit from alkalization of the urine. If the uric acid excretion is increased, allopurinol may provide relief. Cystinuria is a rare disorder of amino acid transport that may be responsible for stones in children and young people.

In all cases, a long-term program of follow-up is helpful. Urinalysis and culture should be performed at regular intervals. The frequency of radiographic examinations depends on symptoms, the persistence of stones in the urinary tract, their size and their number. Complicated patients may benefit from an interdisciplinary approach involving primary physicians, urologists and individuals specifically interested and knowledgeable in stone disease.

REFERENCES

1. Nordin BEC: Metabolic bone and stone disease. Churchill Livingstone, Edinburgh and London, 1973.
2. Boyce WH, Garvey FK: The amount and nature of the organic matrix in urinary calculi: a review. *J Urol* 76: 213-227, 1956.
3. Vermeulen CW, Lyon ES, Fried FA: On the nature of the stone-forming process. *J Urol* 94:176-186, 1964.
4. Yendt ER, Guay FG, Garcia DA: The use of thiazides in the prevention of renal calculi. *Canad Med Ass J* 102:614-620, 1970.
5. Effingen B, Kolb FO: Inorganic phosphate treatment of nephrolithiasis. *Amer J Med* 55:32-37, 1973.
6. Chadwick VS, Modha K, Dowling RH: Mechanism for hyperoxaluria in patients with ileal dysfunction. *New Engl Jour Med* 289:172-176, 1973.
7. Melich RA: Renal calculi and their management. *Med J Aust* 1:308-310, 1976.

The Brown Recluse Spider Bite: New Problems, New Therapy

PHILIP C. ANDERSON, M.D.
Columbia, Mo.

The habitat of the brown recluse spider has been expanding from the lower Missouri Valley, east across Kentucky toward the foothills of the Blue Ridge Mountains and north through Indiana. The spider has traveled (in moving vans) with household goods into farther regions of the country, sometimes to places where the acute necrotic skin ulcer due to its bite has never been seen before.

Since the recognition of the spider and the medical disorder by Atkins of Missouri in 1957, research in loxoscelism has progressively gained for us an understanding of the mechanism of the disease and of the better clinical tactics. The history of this progress¹⁻⁴ and several reviews⁵⁻⁸ are available.

The brown recluse spider, also called the Missouri fiddleback spider or *Loxosceles reclusa*, is a household spider but is nocturnal and reclusive and, so, is not commonly seen. It is a well-studied ecribellate, six-eyed, small spider of the family, Scytodidae. Eighteen species of *Loxosceles* are described for continental North America and adjacent islands. The spider ranges from light yellow-tan to the traditional rich brown, but older adults

become almost black and the distinctive fiddle-shaped marking, also black, on the dorsal carapace may not be easy to see. When intact, the spider is about the size of a 25-cent piece; the legs are long and hairless; and the body is small, unmarked except for the characteristic fiddle, and smooth as compared to the usual house spiders. *Loxosceles* venom consists mostly of enzyme spreading factors, such as hyaluronidase, and only a minute amount of the potent skin-necrotizing fraction. This necrotizing factor has been shown, by Campbell and co-workers, to be a sphingomyelinase D.⁹

The spider is likely to bite only when trapped, for example, in bedding or clothing or stored goods that have been left alone for a few days. Opening and airing trunks or boxes, shaking clothing or bedding, and generally announcing your presence before retiring or unpacking and using various items definitely will prevent loxoscelism. Pesticides are almost useless in controlling the brown recluse spider.

Overall, loxoscelism is much more benign than medical literature suggests. Immunologic studies have shown that many, perhaps most, brown recluse spider bites cause no necrosis but appear on the skin only as a wheal or persisting, tender papule.⁵ Until a few years ago, these were not recognized as spider

bites at all. Persons with such trivial bites seldom consult a physician, and these bites may produce a protective immunity.

The diagnosis of loxoscelism must be based on evidence, either from immediate recovery of the biting spider or from immunologic tests as, for example, the lymphocyte transformation test in our laboratory.⁵ An expert entomologist can identify the spider accurately even from damaged fragments. Because recognition of the spider offers a prospective diagnosis, the physician should try to save this evidence, however badly crushed. The retrospective diagnosis can be established by the lymphocyte transformation test. The responsiveness to venom of blood lymphocyte cells drawn at the time of the bite can be compared to responsiveness of cells about six weeks later to provide convincing evidence for the diagnosis. Only a working presumption, "probable brown recluse spider bite," is possible by observing the development of skin ulceration because other spiders¹⁰ or, rarely, physical accidents can produce the same lesion.

Two to 12 hours after the bite, distinctive changes of central avascular necrosis and inflammation begin in the skin. The bite itself is painless but a papule or small bleb soon arises, which rapidly becomes very painful. A blue-purple, dull-

The author is chairman and professor of dermatology at the University of Missouri School of Medicine, Columbia 65212. His paper was delivered at the Indiana University School of Medicine, Bloomington, in 1977.

Photo courtesy of the Section of Faunistic Surveys and Insect Identification, Illinois Natural History Survey, Urbana 61801.



textured, central core is demarcated by its color and appears to sink gradually down into the skin, while around the core hemorrhage in the skin spreads and around this are rings of erythema and blanching. Depending on the size of the envenomation, the bite may range in diameter from the usual necrotic center 0.5-1 cm. up to about 30 cm. Leukocytosis ($15-25 \times 10^3$ cells/mm.³) accompanies most severe bites. Progressive malaise and fever suggest systemic loxoscelism is evolving. Uncomplicated cutaneous loxoscelism worsens very little after 18 hours. In three to four days, the local visible changes are completed.

If the bite is large (greater than 2 cm.) and in a worrisome location such as finger, eyelid, genitals, or over a large vessel, I'm inclined to use corticosteroids for three to four days without other therapeutic indications. Such patients require day-to-day supervision and encouragement because serious disfigurement seems inevitable. Not only will the final result of healing diminish the

presumed disfigurement to about one-third, usually, but reparative surgery if postponed until after six weeks will offer the most favorable results.

For uncomplicated cutaneous loxoscelism, simple, standard treatment is best. Rest, splinting of the bitten part, and padding to prevent further trauma are routine procedures. Application of cold to or injection in the bite area may not be advisable because vasoconstriction is a major portion of the injury. Relief of pain with anything more than aspirin is seldom needed after the first day. Attempts to excise the early ulceration of cutaneous loxoscelism with the implication that some complicated, terrible events are prevented reliably by this surgery seem to me wholly inappropriate.

Systemic loxoscelism is rare, appearing as a rapid complication to a large envenomation in the skin, and all cases of this type threaten the life of the victim because extravascular coagulation may evolve

suddenly. Large, rapid erosions into fat are associated with the early development of hemolysis (6 to 10 hours), and, in turn, hemolysis may cause coagulation disorders in some patients. Inappropriate coagulation of blood may damage skin or several internal organs including the brain, causing coma to develop quickly. The physician should test urine or serum, or both, to detect the presence of free hemoglobin when either the reaction in the skin to the bite is severe or the systemic illness of the patient begins to worsen over the first 24 hours.

A patient with hemolysis should be followed cautiously to determine that fibrin split products are not increasing or that the kidneys are not being damaged. Symptoms such as headache, drowsiness, nausea, and vomiting should not occur and persist without explanation. Severe loxoscelism appears mostly in young adults and children, but anyone without immune protection against the venom may be affected severely and suddenly.

Treatment for systemic loxoscelism is corticosteroids, 100 mg. prednisone daily or equivalent, given once STAT, and 50 mg. BID thereafter for four or five days. Such therapy seems to have very little effect in lessening the severity of the cutaneous reaction, but, in humans, the benefits can't be confirmed entirely as controlled studies in humans are not possible and an accurately comparable test animal is not available.

Children frequently are bitten by *Loxosceles*, have trivial cutaneous reaction (not necrosis), and seem to become immune. Trivial and mild bites are often seen in children and should not provoke alarm or undue treatment if systemic loxoscelism is absent. The worst hemolytic events I have seen have been in three- to five-year-old children. Pleasantly, these patients had only

mild, spontaneously resolved episodes of disseminated intravascular coagulation, but, unfortunately, renal failure, anuria, and coma developed in about 36 hours and the children appeared to be in dire condition. Peritoneal dialysis or hemodialysis was begun promptly for these children⁵ with immediate, excellent results. The benefits are due much more to replenishing glucose and restoring homeostasis generally than to removing toxins or nitrogenous wastes or venom.

I suggest that the deaths of children reported in medical literature¹¹ may be due mostly to clotting anomalies, less often to sustaining renal failure, and seldom to infection. Each of these risks was minimized and controlled better when dialysis was employed early. Despite the overall good prognosis for

brown recluse spider bites in children, a close watch is appropriate and early hospital care is useful in cases of severe envenomation.

REFERENCES

1. Wilson, JT: Poisoning by the bite of the southern spider, *Transactions of Southern Surgical and Gynecological Abstracts*, 5:406, 1893.
2. Gotten, HB and MacGowan, JJ: Blackwater fever (hemoglobinuria) caused by spider bite, *JAMA*, 114(16):1547, 1940.
3. Atkins, JA, Wingo, CW and Sode-man, WA: Probable cause of necrotic spider bite in the Midwest, *Science*, 126:73, 1957.
4. Geren, CR, Chan, TK, Howell, DE and Odell, GV: Isolation and characterization of toxins from brown recluse spider venom (*Loxosceles reclusa*), *Archives of Biochemistry and Biophysics*, 174(1):90-99, 1976.
5. Anderson, PC: What's new in loxoscelism—1978, *Missouri Medicine*, 74(9):549-552, 1977.
6. Anderson, PC: Brown recluse spider bites—some immunologic aspects, *Illinois Medical Journal*, 153(2):150-153, 1978.
7. Hufford, DC: The brown recluse spider and necrotic arachnidism—a current review, *Journal of the Arkansas Medical Society*, 74(3):126-129, 1977.
8. Majeski, JA and Durst, GG, Sr: Necrotic arachnidism, *Southern Medical Journal*, 69(7):887-891, 1976.
9. Forrester, LJ, Barrett, JT and Campbell, BJ: Red blood cell lysis induced by venom of brown recluse spider—the role of sphingomyelinase D, *Archives of Biochemistry and Biophysics*, 187(2):107-113, 1978.
10. Minton, SA, Jr: Poisonous spiders of Indiana and a report of a bite by *Chiracanthium mildei*, *JISMA*, 65: 425-426, 1972.
11. Vorse, H, Seccareccio, P, Woodruff, K and Humphrey, GB: Disseminated intravascular coagulopathy following fatal brown spider bite (necrotic arachnidism), *Journal of Pediatrics*, 80:1035-1037, 1972.

**NOW YOU CAN
LEASE
THE CAR YOU ALWAYS
WANTED TO OWN**



GIGANTI

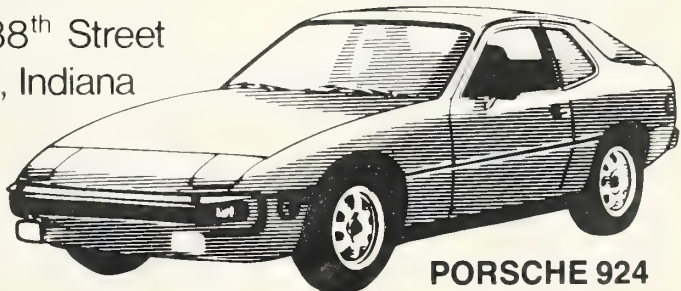
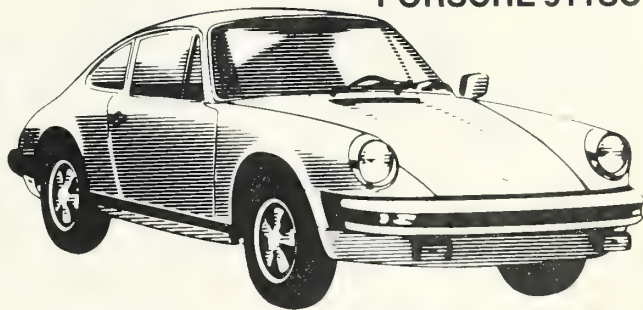
VOLKSWAGEN
PORSCHE
AUDI

INC.

6901 East 38th Street
Indianapolis, Indiana
545-4211

**INDIANAPOLIS' ONLY
PORSCHE AUDI DEALER**

PORSCHE 911SC



PORSCHE 924

Plication of Rectal Mucosa

RICHARD H. APPEL, M.D.
Indianapolis

Because of the restrictions of private practice, it was impossible to carry out complete followups. However, I was aware of only two failures at the time the patients were last seen. I endeavored to attract general surgeons and others to witness plications and results, with only slight success. Since I am retired, I feel a moral responsibility to exhibit this technique more widely, and thus make it available for those who can use it. So I cannot offer tabulating charts, only a recounting of my experiences over 25 years.

The procedure called plication is a simple one. Of course, it can be used only on the mucous membrane, above the skin of the anal canal. Some of the cases revealed a redundancy—a “flooding”—of the mucous membrane, and others only little. So physical examination is of little value. In selecting cases for treatment, you normally must rely on subjective symptoms. These symptoms are usually vague rectal pain, marked pruritis, seldom a backache, sometimes bleeding or burning, but usually pressure, fullness, or vague discomfort. Formerly this kind of rectal pain was described as “rectalgia” and treatment

failed in most cases, or the pain was allocated to a “nerves” complex.

Most of the cases referred to have had surgery. Also, the majority of the cases in this group had been operated by the use of the Whitehead approach. These individuals might or might not reveal any excess of anal tissue, but often had a fixation of the anal skin in upper levels, and looseness of the mucous membrane just above. This produces an inability of the involved tissues to expand and contract normally. Though trouble usually occurred following the Whitehead procedure, there were a few that developed after the familiar stripping type of surgery. The technique is simple. Anesthetic is necessary in order to achieve complete access to the mucosa of the rectal pouch. Thus, a much greater area can be attacked than can be involved in a surgical approach or by the so-called rubber band treatment, and it is desirable to attack all membrane that is accessible above the mucocutaneous level.

Plication consists essentially of strangulation of rectal mucosa. Clumps of this mucosa are retracted downward. These clumps are trans-

Some 25 years ago, I chanced upon a simple technique that proved to be of great value in treating cases in which hemorrhoidectomies had failed to give adequate relief. This approach was that of plication of the mucous membrane of the rectal pouch. The results of the use of this form of treatment were such that I was able to rely upon it in treating cases in which I formerly had failed.

The author, a 1930 graduate of the Indiana University School of Medicine, is a retired proctologist.

fixed at their bases with a #1 chromic suture, which is tied about the base as tightly as possible. Similar clumps are treated likewise until all loose membrane as high as possible in the pouch has been sutured. A running stitch may be used to engulf the adjacent tissue with frequent ties. It is possible to include most of the mucosa of the rectal pouch. These clumps should involve small areas of membrane to attain maximum insult to the tissues. No anal skin should be so treated. The strangulation results in congestion and shrinkage of the mucosa. This shrinkage has been definitely noted where the swelling of mucosa later decreased. Also, it is often possible to encounter increased firmness of the mucosa, or thickening of the underlying tissue, in patients who have had injections prior to later surgery.

Theory indicates that the reason some people have "rectalgia" is because there is a marked difference in rectal sensitivity. This can be observed in routine rectal cases. Some people, unoperated, may have marked hemorrhoidal prolapse with little or no pain. Others may have only mild prolapse but are quite uncomfortable. Some patients may react strongly to injection of internal hemorrhoids, resulting in temporary engorgement, while others have no reaction.

There may be other sutures that are more efficient than #1 chromic; however, since the chromic seemed to satisfy the needs required, I have not experimented with other forms. Also, there was no evidence of sloughing or other complications from the use of chromic. Usually there is merely slight discomfort following this procedure, so it could be accomplished in the office were it possible to obtain access to a wide area of mucous membrane.

I have used plication in many routine cases where a condition of

"flooding" seemed to exist. Whether I achieved much by this, I do not know. However, my results in routine cases seemed to have been better than prior to the use of plication.

I have not tried plication as a substitute for hemorrhoidectomy. Since there are but few cases in which pathology is restricted to the mucous membrane alone, loose anal skin (external piles) can continue downward drag, and thus affect the mucous membrane. One of the worst cases of prolapse that I have seen was in a patient who had had the "rubber band" form of treatment a year before. Here there was marked prolapse of the anal skin.

One diagnostic help in determining whether a case is suitable for this approach is that of injection of internal hemorrhoids. If a patient reports benefit of any degree following 1-3 injections, the prognosis is optimistic for plication.

The application of plication causes only a small amount of discomfort in most cases. One day of hospitalization is usually adequate. I have not been aware of any complications or of sloughing.

CASE REPORT

Following are brief descriptions of the last two cases of plication I performed:

One patient was a man, 39, who had experienced surgery of the Whitehead variety. During the following six months, he had returned twice to the clinic in which he had been operated, complaining of pain with bowel movement and during the day. Also, he had excessive bleeding on several occasions. He was in considerable distress. Examination revealed excessive scarring throughout the upper anal canal, and with no obvious prolapse of the mucosa. The scar was soft, and of itself was not a factor, except that it

prevented any expansion of the membranes of that area. He was taken to surgery and plicated. Relief was almost complete. However, he became worse after two years, and requested a repeat plication. In a checkup after six months, he reported complete relief.

The second patient was a woman, 55, whom I had operated some 15 years before with a typical stripping type of hemorrhoidectomy. Results were completely satisfactory for that period, but vague symptoms of pronounced discomfort began about three months before her return to my office. These symptoms were aggravated when she was sitting, riding, and at night, when in bed. The clinical picture was complicated by the history of low back pain, which had led to two back surgeries, with only partial relief. She was taking a mild sedative every four hours, which complicated an accurate diagnosis. Rectal examination disclosed a soft anal canal with no scarring and no evidence of mucosal prolapse, or flooding. Because of her complaint of extreme discomfort, a plication was performed. Two months later she had complete relief.

It should be mentioned here that while some patients had satisfactory results in a few days, other satisfactory results required two to three months.

SUMMARY

The use of mucosal plication of the mucosa of the rectal pouch, which encompasses tissues unavailable to a surgical approach, has proved to be highly satisfactory. Plication is simple. Its chief indication is in treating patients who have had hemorrhoidectomies with subsequent "rectalgia." It also can be used in treating unoperated patients complaining of pruritis, fullness, and urgency, and who are without visible prolapse.

NEWBORN THYROID SCREENING: Rationale, Methods, Responsibilities

RALPH J. WYNN, M.D.
TJEN O. OEI, M.D.
JAMES C. WRIGHT, M.D.
RICHARD L. SCHREINER, M.D.
Indianapolis

Mental retardation due to undetected neonatal hypothyroidism is preventable. The recent passage in the Indiana State Legislature of H.B. 1234 is a significant step toward lessening the incidence of preventable mental retardation in the state of Indiana.

The bill has the following provisions:

- It adds hypothyroid screening to the previously required PKU screening requirements of newborns;
- It creates an advisory committee to work with the state health department;
- It requires that the health department promulgate regulations for such screening; and
- It gives the advisory committee and the state health department the authority to determine the standards of quality for those laboratories se-

lected to provide these and other screening tests, except for PKU.

It is the purpose of this article to communicate to the practicing physician some of the problems and responsibilities of such a screening program. A brief review of neonatal thyroid dysfunction is also presented.

PATHOGENESIS

Neonatal thyroid dysfunction can be due to fetal or extrafetal factors as seen in *Table 1*. Failure of embryonic development and ectopic placement of the thyroid gland are responsible for approximately two-thirds of the cases of primary hypothyroidism. There are several enzyme defects which interfere with iodide transport, organic binding of iodine, coupling of iodotyrosine and deiodination of the iodotyrosines. These enzyme deficiencies have an autosomal recessive pattern of inheritance. Maternal iodine deficiency is uncommon since the introduction of iodized salt.

INCIDENCE

The results of five large pilot screening programs for thyroxine deficiency indicate that the incidence of congenital hypothyroidism is 1:5,900 live births.¹ Therefore, in Indiana, approximately 10 to 15 infants with congenital hypothyroidism are born each year. This incidence is more than twice that of PKU in the United States and emphasizes the magnitude of the problem.

TABLE 1
Pathogenesis of Neonatal Hypothyroidism

1. Failure of embryonic thyroid development;
2. Ectopic placement of the thyroid gland;
3. Enzyme deficiency;
4. Maternal:
 - Iodine deficiency
 - Iodine excess
 - Antithyroid medications (RAI, PTU, Tapazole)
 - Autoimmunization

From the Department of Pediatrics, James Whitcomb Riley Hospital for Children, 1100 W. Michigan St., Indianapolis 46202.

Acknowledgement: The review of this paper by Drs. Edwin L. Gresham and Ira K. Brandt is appreciated.

TABLE 2

Signs and Symptoms of Neonatal Hypothyroidism*

Icterus > 3 days	73 %
Edema	53 %
Abdominal distention	47 %
Gestation > 42 weeks	47 %
Vomiting	40 %
Poor feeding	40 %
Delay in stooling > 24 hours	36 %
Hypothermia	36 %
Large posterior fontanel	33 %
Respiratory distress	33 %
Peripheral cyanosis	33 %
Birth weight > 4 kg.	27 %
Hypoactivity, lethargy	27 %

*Modified from Smith, D. W., et al.²

SIGNS AND SYMPTOMS

The typical appearance of a cretin child is familiar to most clinicians. In the newborn period hypothyroid infants more commonly have subtle, nonspecific signs and symptoms.² These signs and symptoms, as listed in *Table 2*, are common to several neonatal disorders including sepsis, hypoglycemia and hypothyroidism. An extremely high index of suspicion is required. It is because of these subtle nonspecific signs and symptoms that a screening program is necessary to avoid delay in the diagnosis and initiation of replacement therapy in the thyroxine deficient neonate.

EFFECT ON THE CNS

Primary congenital hypothyroidism is associated with a high fre-

quency of mental retardation. Cretinism accounts for 1-2% of the admissions to institutions for the mentally retarded at a cost of more than \$10,000 per year per admission.³ Most cretins live an extended life. If half the infants with congenital hypothyroidism in Indiana were undetected each year, the conservatively estimated cost to society would be \$3 million for the institutionalized care of these six cretins. In addition, the loss of a productive human life and the tremendous emotional loss to the family must be considered.

There exists a critical period of brain development when thyroid deficiency may cause irreparable damage. Studies of hypothyroid infants have suggested a much better developmental and intellectual prognosis if therapy is initiated prior to 3 months of age, as seen in *Table 3*.⁴ This again emphasizes the importance of early diagnosis.

SCREENING PROGRAMS

Following the pilot studies of mass screening programs for neonatal hypothyroidism by Dussault et al.,⁵ both the Committee of the American Thyroid Association³ and the Committee on Genetics of the American Academy of Pediatrics¹ recommended the establishment and expansion of such screening programs. There exist, however, a number of responsibilities in such a screening program, as noted in *Table 4*.

TABLE 4

Responsibilities of a Screening Program

Informed consent
Testing
Patient retrieval
Confirmation of the diagnosis
Initiation and monitoring therapy
Education and counseling

Mass screening programs are feasible using a radioimmunoassay technique for thyroxine in capillary blood samples collected on filter paper. Such a method is inexpensive, allows for centralized processing and is adaptable to including other tests for metabolic errors of metabolism. Such a method has been in use at the Indiana University Hospitals since the fall of 1976 and has been described in *THE JOURNAL*.⁶

With the ready availability of a large number of kits for performing thyroxine radioimmunoassay, the screening for thyroxine deficiency would appear deceptively easy. A sufficiently large sample population is necessary to generate meaningful statistical values, which are important in the determination of those capillary blood samples that fall in the low thyroxine range and require recall for further evaluation. Even the largest pilot program has reported large interassay variation requiring separate statistical evaluation of each batch of thyroxine filter paper samples.⁵ This indicates that the ability of a small laboratory to generate meaningful data on a small number of specimens is quite limited. To initiate therapy early, the results must be generated with expediency, reported to the physician quickly, and backup testing must be readily available.

Rapid diagnosis and early initiation of therapy are essential to mini-

TABLE 3

Relationship of Age at Onset of Therapy to Subsequent I. Q.*

Age thyroid Rx started	I. Q. (mean)	Per Cent with I. Q. > 85 at 3 years of age
<3 mo.	89	78 %
3-4 mo.	70	13 %
5-6 mo.	71	25 %
>6 mo.	54	0 %

*Modified from Klein, A. H., et al.⁴

mize the harmful effect of congenital deficiency of thyroid hormone on the developing central nervous system. In the mass screening program in Quebec, the elapsed time from the first blood thyroxine determination to the final serum measurements approximates 30 days.⁵

Management and prognosis are dependent on arriving at the correct diagnosis. A low blood thyroxine on filter paper screen is not synonymous with hypothyroidism. Some of the factors responsible are listed in Table 5.^{7,8,9,10} Dussault *et al.*,¹¹ in

TABLE 5

Factors Responsible for Low Thyroxine

Interassay variation
Thyroid binding globulin deficiency
Primary hypothyroidism
Secondary hypothyroidism
Dyshormonogenesis

reporting their experience in the screening of 212,000 newborn infants, showed that 1.84% had a low filter paper thyroxine. By following a low filter paper thyroxine level with a filter paper thyroid stimulating hormone (TSH) assay on the same samples, the recall rate was decreased to 1.1%.

Such combined use of capillary blood filter paper assays for thyroxine and thyroid stimulating hormone enables the physician to better screen for thyroid dysfunction. The use of a statistically determined value for the individual assay lessens the effect of interassay variation. In those infants with thyroid binding globulin (TBG) deficiency, the thyroxine is marginally low with a normal TSH level reflecting an adequate level of circulating active thyroid hormone. In primary hypothyroidism a very low or absent level of thyroxine results in a markedly increased secretion of TSH

from the pituitary gland. However, in secondary hypothyroidism due to pituitary deficiency, both the thyroxine and TSH levels will be extremely low. It must be emphasized that such screening only identifies a population of neonates at risk and that the diagnosis must be confirmed by measurements of serum hormone concentrations.

A plan for the followup of newborn infants with an abnormally low thyroxine value must be developed by each screening program. The use of the absolute values such as reported recently by Dussault *et al.*,¹¹ can lead to errors in interpretation and diagnosis. Confirmation of the diagnosis, initiation and monitoring of thyroxine replacement therapy must be coordinated. Education and counseling must be provided.

CONCLUSION

The recent thyroid screening legislation is a significant step toward lessening the incidence of preventable mental retardation in Indiana. To avoid the difficulties that occurred with the PKU screening program, we must be cognizant of our responsibilities as physicians to advocate a well designed and controlled method for performing such screening.

Thyroxine screening should be more than the mere testing of newborn infants for low blood thyroxine levels. It should be promoted within the context of an integrated program where there are facilities and resources for the coordination of testing, retrieval, diagnosis, treatment and followup. This goal can best be accomplished under the guidance of a regional advisory committee or commission to determine the scope of metabolic and screening programs, the techniques for collection and transmission of specimens, the adequacy of laboratory methodology and the methods

for transmitting results to the physician. The establishment of regional screening centers would most efficiently meet the needs of trained laboratory technologists, clinical pathologists and other physicians familiar with the function of the neonatal thyroid.

REFERENCES

1. Scriver, CR, Feingold, M, Mamunes, P, Nadler, HL: Screening for congenital deficiency of thyroid hormone. *Pediatrics* 60:391-395, 1977.
2. Smith, DW, Klein, AM, Henderson, JR, Myrianthopoulos, NC: Congenital hypothyroidism—signs and symptoms in the newborn period. *J. Pediatrics* 87:958-962, 1975.
3. Fisher, DA, Burrow, GN, Dussault, JH, Hollingsworth, DR, Larsen, PR, Man, EB, Walfish, PG: Recommendations for screening programs for congenital hypothyroidism. *J. Pediatrics* 89:692-694, 1976.
4. Klein, AH, Meltzer, S, Kenny, FM: Improved prognosis in congenital hypothyroidism treated before age three months. *J. Pediatrics* 81:912-915, 1972.
5. Dussault, JH, Coulombe, P, Laberge, C, Letarte, J, Guyda, H, Khoury, K: Preliminary report on a mass screening program for neonatal hypothyroidism. *J. Pediatrics* 86:670-674, 1975.
6. Oei, T, Wynn, R, Nordschow, C, Hoke, S, Ryder, K: Screening for congenital hypothyroidism using an insolubilized radioimmunoassay technique. *J. Indiana State Med. Assoc.* 71:689-691, 1978.
7. Fisher, DA: Thyroid function in the premature infant. *Am. J. Dis. Child.* 131:842-844, 1977.
8. Bernard, B, Oddie, TH, Fisher, DA: Correlation between gestational age, weight, or ponderosity and serum thyroxine concentration at birth. *J. Pediatrics* 91:199-203, 1977.
9. Cuestas, RA, Lindall, A, Engel, RR: Low thyroid hormones and respiratory—distress syndrome of the newborn. *N. Engl. J. Med.* 295:297-302, 1976.
10. Fisher, DA: Advances in the laboratory diagnosis of thyroid disease. Part I. *J. Pediatrics* 82:1-9, 1973.
11. Dussault, JH, Morissette, J, Letarte, J, Guyda, H, Laberge, C: Modification of a screening program for neonatal hypothyroidism. *J. Pediatrics* 92:274-277, 1978.

ABSTRACT

Screening programs for congenital neonatal hypothyroidism using filter paper blood specimens have been shown to be effective as part of mass screening programs. Unfortunately such programs have utilized methods and reagents which are not readily adaptable to other, and particularly smaller, centers. We have adapted a commercially available insolubilized antibody or solid state RIA technique for screening purposes. There is excellent sensitivity utilizing this method.

TJEN O. OEI, M.D.
RALPH J. WYNN, M.D.
CARLETON D. NORDSCHOW, M.D.
KENNETH W. RYDER, M.D.
STANLEY R. HOKE, B.A.
Indianapolis

Screening for Congenital Hypothyroidism Using an Insolubilized Radio Immunoassay Technique

The first mass screening for neonatal hypothyroidism began in Quebec, Canada, in April 1974. Dussault and coworkers have used a conventional radioimmunoassay (RIA) to measure thyroxine (T_4) concentration in eluates of filter paper blood spots. Other mass screening centers have subsequently been established in Pittsburgh^{1,2} and Toronto.^{3,4}

Based on these pilot studies, the incidence of neonatal hypothyroidism has been found to be approximately 1 in 6,000 births. Early detection of this disorder is essential to the prevention of irreversible mental deficiency secondary to inadequate thyroxine concentrations during neonatal development.

Kline and coworkers have shown the importance of initiating treatment of congenital hypothyroidism before three months of age.⁵ When thyroxine replacement was begun before the age of 3 months, 70% of the patients subsequently had an IQ

of above 83. When treatment was delayed beyond 3 months of age, 85% manifested mental deficiency.

However, early detection of neonatal hypothyroidism is quite difficult based solely on clinical criteria. For this reason, the American Thyroid Association has recommended mass screening for congenital hypothyroidism using a filter paper T_4 assay.⁶ They further recommend that this be combined with existing newborn screening programs.

At Indiana University Medical Center, three filter paper "spots" of blood are routinely obtained from infants at 2 to 4 days of age by heel stick.⁷ One sample is used for phenylketonuria (PKU) screening, one for T_4 determinations and the other reserved for a repeat determination when necessary. We would like to report here the adaptation of a commercially available insoluble antibody (solid state) RIA procedure for T_4 screening.

Previous T_4 screening procedures have employed reagents which are not generally commercially available. The emergence of a solid state RIA method for T_4 measurement has both decreased technologist time and eliminated many of the inherent pitfalls of conventional assay methods.

MATERIALS AND METHODS

Patients of this study were randomly selected from infants born at Indiana University Hospital during February and March, 1977. All were clinically normal at birth and, where follow-up has been possible, none have exhibited any manifestations of congenital disease to date. Both conventional filter paper blood spots and capillary tube serum samples were obtained from each infant at 2 to 4 days of age.

Thyroxine concentration in the infant's serum was measured using the T_4 gamma coat RIA kit manufactured by Clinical Assays, Inc. In this procedure the antibody is supplied covalently bonded to the plastic assay tube. Assays were performed in accordance with the manufacturer's recommendations.⁸

Thyroxine concentration in the filter paper was measured as follows: a quarter-inch circle was punched from the center of the filter paper blood spots and added to an assay tube containing 0.5 ml of the supplied buffer, and incubated at room temperature for 20 minutes. A standard curve was prepared by adding 5 microliters of aqueous/serum standards (1, 4, 12, and 30 micrograms of thyroxine per dl) to an assay tube containing 0.5

From the Department of Clinical Pathology, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

COMPARISON OF T₄ (WHOLE BLOOD FILTER PAPER)
WITH T₄ (SERUM) MEASURED BY SOLID STATE RIA

Least squares	
Slope, m	0.40
y-intercept, b	3.15
Std. error, S _{x,y}	1.51
t-test	
Bias	5.90
S.D. diff	2.29
Correlation coefficient, r	0.62

TABLE 1

ml of buffer. 0.5 ml of 125-I labeled thyroxine (supplied) was added to each tube and incubated for an additional 45 minutes at room temperature. Following the second incubation, the fluid phase was removed by decantation, washed once with distilled water, and the remaining radioactivity determined using a Packard gamma counter. Counts per minute for the standard tubes were plotted versus concentration on a two cycle semi-log paper in the usual manner.

RESULTS

Patients' T₄ concentrations measured in both whole blood filter paper spots and in serum are shown in Figure 1. As can be seen, the serum thyroxine concentration is usually greater than the corresponding whole blood value. These results are generally in agreement with previously published studies.⁹ These two methods have been statistically compared as outlined by Westgard^{10,11} and the least squares and t-Test parameters are shown in Table 1.

DISCUSSION

As seen in Table 1, the correlation coefficient and the slope are less than ideal, assuming negligible random error in the reference method. However, there are two important intrinsic differences in these methods which must be considered when evaluating these statistical data:

First, a different specimen source was used in each assay. Filter paper T₄ was measured on dried whole blood, whereas serum was utilized in the T₄ RIA determination. Presently the effect of hematocrit on filter paper T₄ assays remains controversial, so it is not possible to estimate the effect of utilizing these different specimen sources for analysis.

Second, when using blood absorbed into filter paper the assumption is made that a constant amount of blood is applied each time and that a quarter-inch diameter circle contains 5 microliters of serum. However, it is well known in the practical application of such a system that the amount of blood may vary significantly.

Therefore, great care must be

taken to establish a uniform method of acquiring filter paper blood specimens, and quantitative determinations utilizing these specimens must be interpreted with a knowledge of this variability.

Also, Westgard has pointed out the fallacy of strict reliance on correlation coefficient when the biologic range of values is limited, as in the present case. When a patient is encountered with a T₄ concentration of less than 4.6 µg/dl or less than two standard deviations from the intra run mean (whichever is higher), our procedure is to recall the patient as soon as possible to obtain plasma for both a T₄ and for thyroid stimulating hormone (TSH) quantitation. It has only been necessary to recall 11 of the past 1,400 patients tested.

WHOLE BLOOD FILTER PAPER T₄ VERSUS
SERUM T₄ AS MEASURED BY SOLID STATE RIA

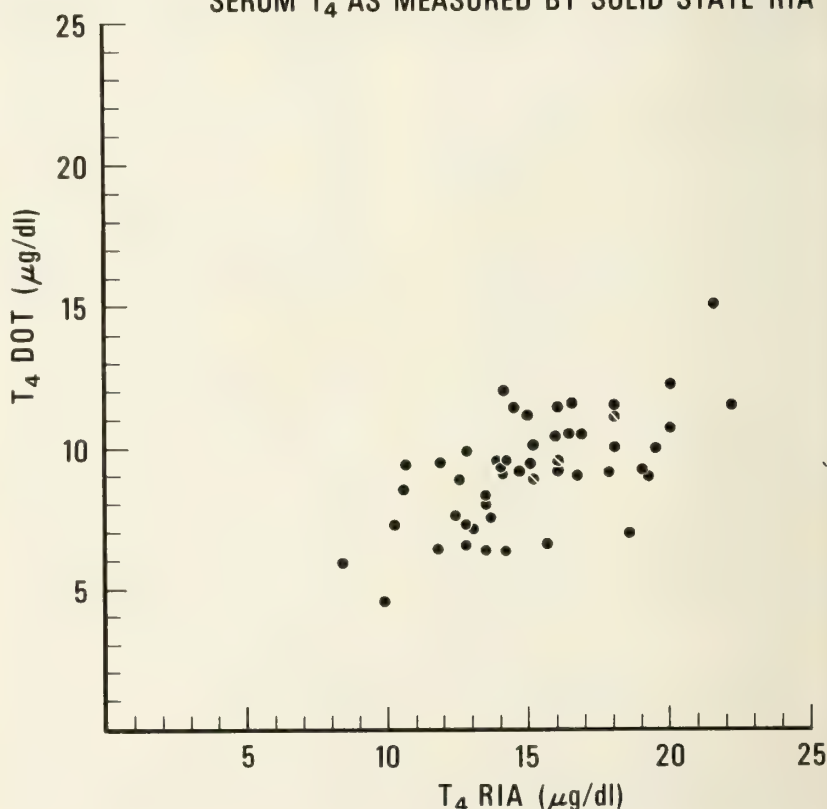


FIGURE 1

SUMMARY

Good therapeutic success has been demonstrated by completing all screening and necessary follow up tests and initiating thyroid replacement therapy by the time the infant has reached 1 month of age. The large program presently in effect in Quebec has demonstrated that this timetable can indeed be a reality.¹ The Canadian experience has already shown both medical as well as cost-effective benefits of such a program.⁶ The method described herein, an adaptation of recent developments and improvements in RIA to such a screening program renders such screening possible for small hospitals and clinics as well as large regional referral centers. It is hoped that this will help stimulate the search for neonatal hypothyroidism.

REFERENCES

1. Dussault, JH, Coulombe, P, Laberge, C, *et al.*, "Preliminary report on a mass screening program for neonatal hypothyroidism," *J. Pediatrics*, 86: 670-4, 1975.

2. Dussault, JH, Letarte, J, Guyda, H, and Laberge, C, "Thyroid function in neonatal hypothyroidism," *J. Pediatrics*, 89:541-4, 1976.

3. Klein, AH, Agustin, AV, and Foley, TP, "Successful laboratory screening for congenital hypothyroidism," *Lancet*, 77-79, July 13, 1974.

4. Klein, AH, Foley, TP, *et al.*, "Neonatal thyroid function in congenital hypothyroidism," *J. Pediatrics*, 89: 545-9, 1976.

5. Klein, AH, Meltzer, S, and Kinny, FM, "Improved prognosis in congenital hypothyroidism treated before age three months," *J. Pediatrics*, 81:912-15, 1972.

6. Fisher, DA, Burrow, GN, *et al.*, "Recommendations for screening programs for congenital hypothyroidism," *J. Pediatrics*, 89:692-4, 1976.

7. Dussault, JH, Morissette, J, *et al.*, "Factors influencing results for thyroxine concentration in blood as measured in paper filter spots in a screening program for neonatal hypothyroidism," *Clinical Chemistry*, 22:1292-4, 1976.

8. T₄ Serum RIA Gamma Coat, Clinical Assay, Cambridge, Mass., Manufacturer's product insert.

9. Dussault, JH, Laberge, C, "Dosage de la Thyroxine (T₄) Par method Radioimmunologique dans l'eluat de sang seché nouvelle method de dépistage de l'hypothyroidie neonatal?" *L-union medical du Canada*, 102: 2062-4, 1973.

10. Westgard, JO and Hunt, MR, "Use and interpretation of common statistical tests in method-comparison studies," *Clinical Chemistry*, 19:49-57, 1973.

11. Westgard, JO, Carey, RN, and Wold, S, "Criteria for judging precision and accuracy in method development and evaluation," *Clinical Chemistry* 20: 825-33, 1974.

★
Specialized Service

IN
PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

Since 1899

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Southern Indiana Office: Kenneth W. Moeller, Representative
1810 Broad Ripple Avenue Telephone: (317) 255-6525
Mailing Address: P.O. Box 20132, Indianapolis 46220
Northern Indiana Office: Douglas O. Sellon, Representative
120 LaSalle West Bldg., Suite 304
South Bend, In. 46601 Telephone: (219) 289-7332

Further Observations on New Tube Tests for Rapid Detection of Hemoglobin S

WEI-PING LOH, M.D.

Gary

EDWARD J. HICKS, Ph.D.

Indianapolis

Routine testing for sickle cell disease in the black population has been popular in recent years. The value of a new tube test for rapid detection of hemoglobin S (Hb-S) has been previously reported.^{1,2,3} Yet, such tube tests cannot distinguish heterozygous S (AS, sickle cell trait) from homozygous S (SS, sickle cell anemia), and hemoglobin electrophoresis has to be performed for the differentiation. The purpose of this investigation is to evaluate another tube test that can rapidly distinguish AS from SS without hemoglobin electrophoresis.

Dr. Loh is a certified hematologist who is chief pathologist at Methodist Hospital of Gary, Inc.; he is a clinical professor of pathology at Indiana University N.W. Dr. Hicks is an associate professor of clinical pathology at the I.U. School of Medicine, Indianapolis.

MATERIALS AND METHODS

Reagents for this new tube test SickLeQuik™ were provided by the General Diagnostics, Division of Warner-Lambert Company, Morris Plains, N.J. They consist of toluene, aqueous phosphate buffer, saponin, sodium hydrosulfite and a stabilizer. All reagents are in a ready-to-use 10x75 mm capped tube. The test was performed by adding 100 ul (0.1 ml) or two drops of whole blood to the tube. The contents were then well mixed and allowed to stand for five minutes. The mixture was finally centrifuged for five minutes at approximately 3,400 RPM or allowed to stand in a vertical position for two hours. Known controls were always run each time by each technologist who performed the tests.

Only the layer at the interface and the lower aqueous phase in the tube are significant for interpretation of the results. The result was recorded as AA (normal adult hemoglobin) if the interface (between upper toluene layer and lower aqueous layer) had no distinct red band and the lower aqueous

layer was dark red (*Figure*). The result was recorded as SS if the interface had a distinct red band and the lower aqueous layer had a pale straw color. The result was recorded as AS if the interface had a distinct red band and the lower aqueous layer had varying shades of red color. The distinct red band was formed by hemoglobin S, which came from the lysed red cells (in the presence of toluene and saponin) and became insoluble in the aqueous phase after reduction by the sodium hydrosulfite.

Between July 18 and Sept. 30, 1977, this new tube test was performed simultaneously with the SickLeDex™ test (Ortho Diagnostics, Raritan, N.J.) and cellulose acetate hemoglobin electrophoresis on 200 blood samples at the Methodist Hospital of Gary, Inc., Gary, Ind.

RESULTS

There was 100% correlation between the results from SickLeQuik and cellulose acetate hemoglobin (SickLeDex cannot differentiate between AS and SS samples). The results were as follows:

AA	110 samples
AS	83 samples
SS	2 samples
SC	4 samples
AC	1 sample
<hr/>	
TOTAL	200 samples

The 200 samples included a number from sickle cell families. They are not a true representation of the hemoglobin distributions in our black population. A few blood samples were purposely kept in the refrigerator for two weeks before re-testing, and the age of the samples did not seem to affect the test results. On the basis of electrophoretic study, the lowest portion of hemoglobin S detected by this new tube test among the 83 AS samples was 25.5%.

DISCUSSION

A test capable of differentiating the heterozygous state from the homozygous state was previously developed by Huntsman *et al* in 1970,⁴ and improved by Serjeant and Serjeant.⁵ This method departs from other solubility tests in that

turbidity is not used to detect the presence of sickling hemoglobin. Interpretation of the results obtained in this investigation is similar to that found in the Huntsman *et al* procedure, but the differences in the two procedures are the stabilization of the reagents and the stabilization of the endpoint of the reaction by the addition of toluene.

In view of these test results, this new tube test appears to be speedy and accurate, and can be routinely employed as a screening procedure prior to electrophoresis. In comparison with other tube tests, it has the advantageous capability of distinguishing AS from SS without electrophoresis. The test procedure is simple to perform. The endpoint is easy to read. No major or expensive equipment is needed. It has been recently recognized that electrophoresis is an efficient screening procedure for cord blood at birth.⁶ But, in absence of electrophoresis, this new tube test should be highly recommended as a differential and screening procedure for all blood samples.

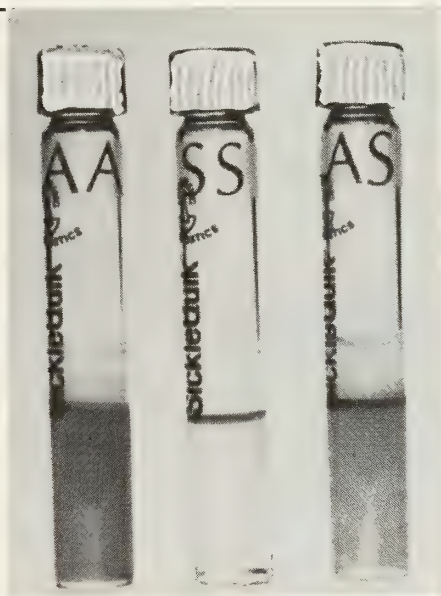
As is the problem with all tube solubility tests, this new tube test cannot detect the presence of other nonsickling hemoglobins, nor can it distinguish sickle cell trait (AS) from the sickle cell variants (SC, SD, S-Thal, etc.). Additional investigation is being conducted for reducing or eliminating the disadvantages. Other investigations in progress involve further improvements on speed and reagents and evaluations of false endpoints. The results will be reported in subsequent communications.

SUMMARY

A new tube test for rapid detection of hemoglobin S and differentiation between AS and SS is described and compared with another tube test and electrophoresis. This new tube test was found to be accurate, rapid and easy to perform, particularly as a differential screening test. The test is highly recommended both for use in the physician's office and in mass testing programs when hemoglobin electrophoresis is not readily available.

REFERENCES

1. Loh, WP: A new solubility test for rapid detection of hemoglobin S, *JISMA*, 61:1651-1652, 1968.
2. Loh, WP: Evaluation of a rapid test tube turbidity test for the detection of sickle cell hemoglobin, *Am. J. Clin. Path.*, 55:55-57, 1971.
3. Loh, WP: Comparison of the screening tests for sickle cell disease, *JISMA*, 66:1089-1090, 1973.
4. Huntsman, RG, Barclay, GPT, Canning, DM and Yawson, GI: A rapid whole blood solubility test to differentiate the sickle-cell trait from sickle-cell anemia, *J. Clin. Path.*, 23:781-783, 1970.
5. Serjeant, BE and Serjeant, GR: A whole blood solubility and centrifugation test for sickle cell hemoglobin: a clinical trial, *Am. J. Clin. Path.*, 58: 11-13, 1972.
6. Hicks, EJ, Loh, WP, Hamilton, R and Horton, R: Cord-blood screening considerations, *Clin. Chemistry*, 23:1551-1555, 1977.



AA—Normal adult hemoglobin, no red band, lower layer dark red;
 SS—Sickle cell anemia, red band at interface, lower layer pale straw;
 AS—Sickle cell trait, red band at interface, lower layer pink.

Reconstructive Ear Surgery

GEORGE W. HICKS, M.D.
J. WILLIAM WRIGHT, JR., M.D.
J. WILLIAM WRIGHT, III, M.D.
Indianapolis

Ear surgery has progressed remarkably in the past decade. Many physicians outside the discipline of otology are unaware of the many new surgical solutions available for the treatment of chronic ear disease. Ear surgery which routinely resulted in an open mastoidectomy cavity has been replaced by present techniques resulting in a more physiologic, anatomic and functional ear. Preservation or rebuilding of the posterior bony ear canal wall with aeration of the mastoid cavity has been a major factor in modern ear surgery.

The chances of good hearing after ear surgery are improved when the posterior canal wall is preserved and an open mastoidectomy cavity avoided. In the patients whose disease eradication necessitates removal of this bony wall, present techniques enable its reconstruction so that the mastoid cavity no longer opens to the outside and the hearing conduction mechanism can be more efficiently rebuilt. Also, techniques in the repair and rebuilding of the tympanic membrane and ossicular chain are constantly improving.

Although it is impossible to discuss all of the numerous options now available to the ear surgeon when confronted with an ear damaged by chronic infection, we will touch upon some of the newer techniques we find quite beneficial.

ANATOMY AND TERMINOLOGY

For purposes of clarification, a brief review of the pertinent ear anatomy and a definition of terms follows.

The ear is divided into three parts: (1) the external or outer ear, consisting of the auricle and ear canal; (2) the middle ear, which houses the three hearing bones (malleus, incus, stapes) and is connected to the nasopharynx by the eustachian tube; and (3) the inner ear which contains the organ for hearing (cochlea) and equilibrium (labyrinth). (*Figure 1*). The mastoid area is immediately posterior to the posterior bony ear canal wall. The middle ear opens into the mastoid area through a narrow opening just above and posterior to the hearing bones called the aditus. The lateral border of the middle ear is the tympanic membrane; the medial wall is bone, medial to which are the inner ear structures. The facial nerve crosses the medial wall of the middle ear and descends vertically in the mastoid region. The ossicles of the middle ear are the malleus, which attaches to the eardrum; the incus, interposed between the malleus and stapes; and the stapes, whose footplate closes the oval window leading into the inner ear.

To otologists, certain labels mean certain specific entities. Chronic otitis media indicates, usually, a permanent eardrum perforation. A special type of chronic middle ear infection is a cholesteatoma. Cholesteatoma refers to the presence of squamous epithelium in the middle ear or mastoid area. Desquamation, enlargement and enzymatic action

cause bony destruction and erosion of important adjacent structures. Chronic otitis media with cholesteatoma is always safely treated only by surgery. Improperly treated chronic otitis media may lead to meningitis, epidural abscess, brain abscess, thrombosis of the sigmoid sinus or jugular vein, septicemia, suppurative labyrinthitis, facial paralysis, and subperiosteal abscess. Repeated ear infections may also result in tympanosclerosis, which is thick plaques of scar tissue within the eardrum and/or lining of the middle ear.

EUSTACHIAN TUBE

The eustachian tube is being discussed separately for it is the most important factor in the development of ear disease. Basically, the eustachian tube provides a pathway for replenishing the air in the middle ear space. It may also play a role in clearing the middle ear secretions. A normally functioning eustachian tube helps the development of the mastoid air cell system.

Nasal allergy, recurrent upper respiratory infection, lymphatic hyperplasia of Waldeyer's ring, chronic rhinosinusitis, or cleft palate all may cause malfunction of the eustachian tube and lead to middle ear infections. Because of a poorly functioning eustachian tube, often beginning in childhood, repeated acute ear infections may occur, often leading to tympanic membrane collapse (atelectasis), perforation, squamous epithelium ingrowth, cholesteatoma formation, and, thus, a serious chronic ear infection. Disease in the form of polypoid mucosa, granulation tissue and cho-

From Otologic Associates, Inc., 5506 E. 16th St., Suite 22, Indianapolis 46218.

A copy of the references pertaining to this paper may be obtained by writing THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

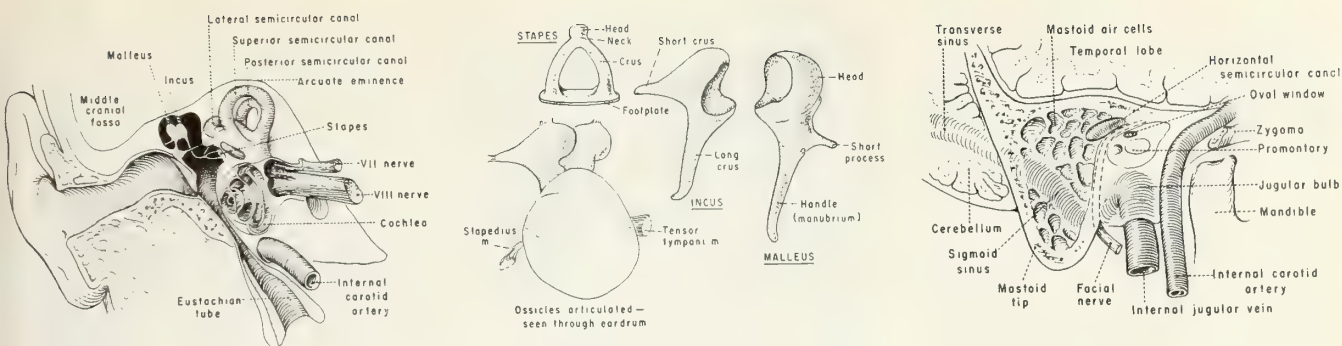


FIGURE 1

Basic anatomy of the ear. Left: a coronal section of a right ear. Middle: the middle ear ossicles. Right: a right lateral view.

lesteatoma may then block the tympanic end of the eustachian tube. Thus, even if the original causes of the eustachian tube malfunction are corrected or "outgrown," e.g., allergy or enlarged adenoids, the disease now in the middle ear perpetuates the obstruction.

In chronic otitis media with irreversible changes in the middle ear mucosa, only surgery can restore eustachian tube function. Very often at the time of surgery diseased tissue is found and removed from the eustachian tube orifice as well as other areas of the middle ear with a subsequently successful surgery and aerated middle ear. In our opinion, there is no reliable pre-operative test of eustachian tube function. Nor is there any test with any prognostic value. The only true test of poor eustachian tube function is satisfactorily performed ear surgery which fails because of absent middle ear aeration.

In revising these ears at subsequent surgery, eustachian tube dysfunction has been satisfactorily corrected by placement of a permanent indwelling eustachian tube prosthesis.

PRE-OP EVALUATION

Radiologic Exam: All patients undergo polytomography of the temporal bone.¹ The course of the facial nerve, the condition of the ossicles, the presence or absence of bone covering the dura, lateral sinus or facial nerve, the degree of tympanosclerosis, the presence or ab-

sence of fistulae, the extent of cholesteatoma, as well as many other facts make this examination invaluable. We feel that routine mastoid films are of limited help.

Audiology: Complete audiologic assessment is obtained on all patients. This consists of air, bone and speech discrimination. Other tests are obtained as needed. All patients are also fully evaluated with tuning forks.

Discharging Ears: Acute exacerbations of a chronic ear infection are treated accordingly. But we do not hesitate to operate on an ear which continues to discharge. Whether an ear is "wet" or "dry" seems to have little bearing on the surgical result.

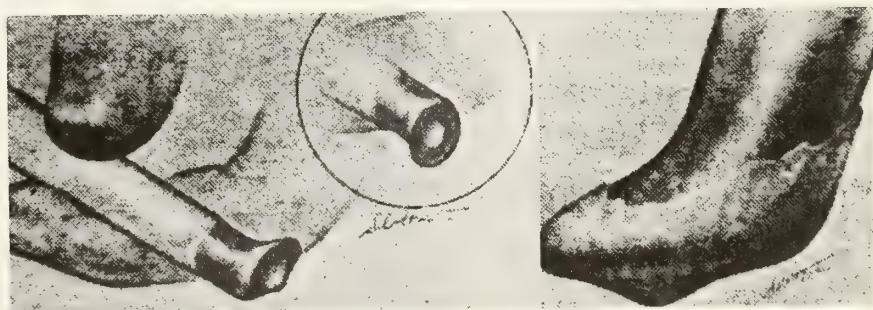
Patient Consultation: Since most ear surgery is elective, all surgical options are presented to the patient before surgery. Things discussed are use of implant materials, the use of homograft tissue, and the possible need for a two-stage procedure as well as realistic goals of the surgery.

SURGICAL TECHNIQUES

The ear surgeon must be prepared to deal with any and all situations presented to him at the operating table. All available techniques have their use dictated by a number of interacting factors. The stage of the disease process, the clinical condition of the patient, the desires of the patient, the experience of the surgeon, and residual nerve function all play a role in the choice of operation.

For convenience, we shall limit the discussion to the more commonly performed procedures in our practice:

Tympanic Membrane Surgery. Chronic otitis media almost always causes some eardrum defect. Perforations of various sizes and locations are often present. Quite often, when there is an eardrum remnant, it is atrophic, severely retracted and/or thick with scar tissue, therefore often necessitating removal of the drum remnant. Eardrum repair or replacement is almost exclusively



Temporalis muscle fascia draped over metallic ear mold for treatment in buffered formaldehyde.

FIGURE 2

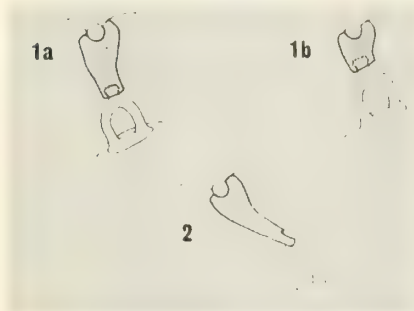
now done with grafts of temporalis muscle fascia. These grafts can be placed either medial or lateral to the eardrum perforation.^{2,3} The difficulty is that when the perforation is very large, total, or anterior, grafting becomes more difficult.

The problems of graft movement (lateralization), "non-take" of the graft, and blunting (the angle between the graft and anterior canal wall fills with scar tissue) increase almost in direct proportion to the size of the perforation. Innumerable techniques have been described to

		MALLEUS HANDLE	
		Present	Absent
STAPES ARCH	Present	A Malleus-stapes assembly (59.2%)	C Tympanic strut assembly (7.8%)
	Absent	B Malleus-footplate assembly (23.2%)	D L-shaped prosthesis (8.2%)

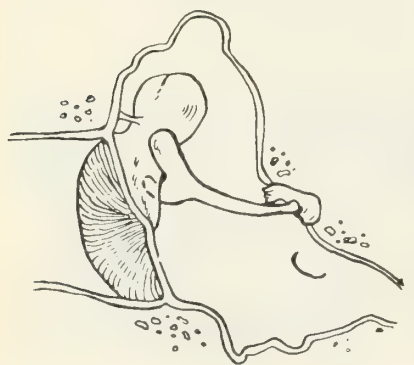
A classification of ossicular defects and the incidence of occurrence according to Austin.

FIGURE 3



Various configurations of bone interposition between malleus and the head of the stapes.

FIGURE 4



Bone interposition from the malleus handle to the stapes footplate.

FIGURE 5

avoid these problems.^{4,5,6} A new procedure described by Perkins⁷ has solved most tympanic membrane problems for us. This method enables the grafting material to be shaped on a metal mold (Figure 2). It is then treated with buffered formaldehyde. This process strengthens the graft and causes it to retain the conical shape imparted by the mold. This graft is then removed from the mold and placed into the ear and attached to the malleus. This procedure obviates the problems mentioned above and is easily used in conjunction with other procedures that may have to be done.

Ossicular Chain Reconstruction.

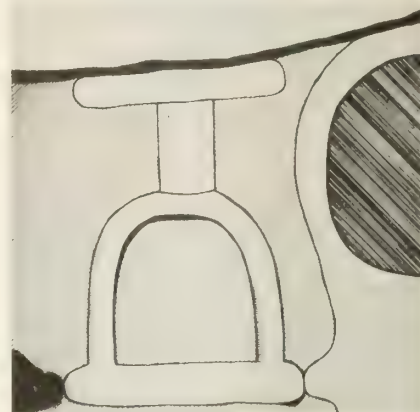
Chronic ear disease often results in damage to the hearing bones. The incus is most commonly damaged and the loss of its long process is the most common cause of ossicular discontinuity.⁸ Austin⁹ has classified defects according to the presence or absence of the malleus and stapes arch (Figure 3). Present day ossicular chain reconstruction most often consists of the interposition of autogenous or homogeneous bone between remaining ossicles. Some typical examples of these are as follows:

- Malleus present-stapes present. Bone is interposed between the malleus and the head of stapes. This bone may be either autograft or homograft bone, which is shaped so as to fit snugly between the two remaining ossicles (Figure 4). This method is much more effective than the transposition techniques, which we rarely use.

- Malleus present-stapes absent. Bone interposition from the malleus handle to the stapes footplate is the procedure of choice (Figure 5). We have also used a Plastipore* T.O.R.P. (Total Ossicular Replacement Prosthesis) from the footplate to the malleus.

- Malleus absent-stapes present. This is an unusual problem seen infrequently, usually after radical surgery with malleus amputation. Our choice here is either a one-stage procedure using a Plastipore drum-to-stapes prosthesis (Figure 6) or

homograft tympanic membrane with attached malleus and incus (Figure 7) or a two-stage procedure using a homograft in an ear previously having radical surgery.



Plastipore Drum-to-Stapes (D.S.) prosthesis fitted between the head of the stapes and the overlying eardrum.

FIGURE 6



Homograft tympanic membrane with attached malleus and incus.

FIGURE 7

- Malleus absent-stapes absent. This is the result usually after radical mastoid surgery. The surgery is often performed to remove residual infection, to make it a "safe ear" and to improve the hearing. One or two-stage surgery is available. The radical cavity can be revised and

*Plastipore™, Richards Manufacturing Company, Memphis, Tenn.

hearing improved with use of a T.O.R.P. from the stapes footplate to the overlying fascia graft (*Figure 8*). In a two-stage procedure both the function and anatomy of the ear may be restored. The first stage consists of removal of residual disease, if present, and reconstruction of the posterior canal wall with homograft dura and bone pate and placement of a homograft tympanic membrane - malleus - incus (*Figure 9*). At the second stage the hearing chain mechanism is connected by use of ossicular interpositions, a stapedectomy, a stapes prosthesis to the footplate or a Plastipore implant. Homograft bone, homograft knee cartilage, and Proplast* have also been described for rebuilding the posterior wall but we have not used those methods.

It should also be noted that mastoid cavities can be obliterated with bone chips or pate in association with middle ear reconstruction. When one can be absolutely certain of no disease in the mastoid bowl, this is possible. Reconstruction of

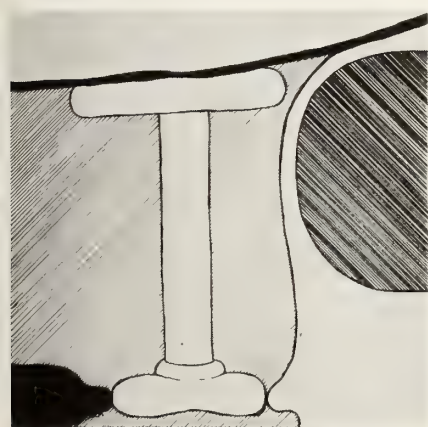


FIGURE 8
A T.O.R.P. (Total Ossicular Replacement Prosthesis) between the stapes footplate and the overlying fascia graft.

the posterior canal wall appears to be more physiologic and safer. An aerated mastoid results in better eardrum compliance and less need for air re-infusion. And an aerated mastoid avoids the danger of burying unsuspected squamous epithelium.

*Proplast, Vitek, Inc., Houston, Texas

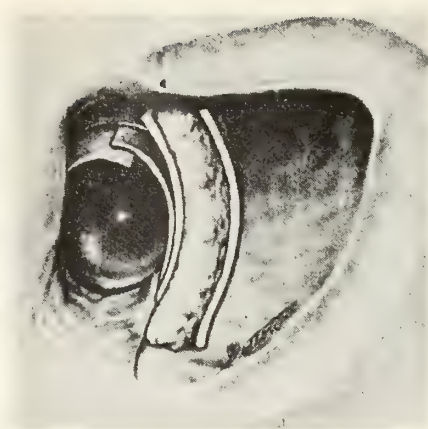


FIGURE 9
First stage reconstruction using homograft dura filled with bone pate. A homograft tympanic membrane-malleus-incus en bloc is also in place.

One must remember that although the clinical conditions are listed separately, in actuality the ravages of chronic ear disease can so damage the ear structures that various combinations of hearing chain defects occur. In addition, one often must deal with temporal lobe herniations, brain abscess, sigmoid sinus and facial nerve exposure, fistulae of the cochlea or lateral semicircular canal, eustachian tube obstruction and extensive middle ear scar tissue (tympanosclerosis). And yet, with meticulous and knowledgeable otologic surgery, a safe and functional ear can result!

BACKGROUND-SUMMARY

During the latter 19th Century and into the 1950s, ear surgeons were primarily concerned with preventing the serious complications of chronic ear disease. The only surgery performed was the mastoidectomy. This procedure resulted in eradications or control of chronic ear disease and thus afforded the patient a "safe" ear. But also as a result, the patient frequently ended up with poor hearing and intermittent ear drainage. It was soon realized that operations were needed that combined the eradication of disease and the restoration of hearing. When the operating microscope was developed in 1937, these advances became a distinct possibility.

An operation called tympanoplasty was introduced in the early 1950s in which eardrum defects were repaired and the eardrum repositioned so as to make contact with whatever remnants of the hearing bones (ossicles) remained, either as a result of disease or the surgeon's attempts to remove disease. This eardrum-ossicle contact resulted in the classification of various tympanoplasty operations still basically in use today (*Figure 10*). But the need to remove disease still often resulted in an open mastoidectomy cavity, which led to disappointing results. Healing of the mastoidectomy cavity was still difficult to maintain and the hearing results often poor. Also, attempts at rebuilding the ear mechanisms that transmit sound, i.e., the eardrum and hearing bones, were not very effective.

It was soon realized that the destruction of the posterior part of the ear canal wall, as is done in mastoidectomy surgery, had a negative influence on reconstruction of the sound conducting mechanism of the ear and prevented restoration of hearing after disease removal.

In 1958 Jansen¹⁰ developed a surgical technique called the posterior tympanoplasty, which was an attempt to preserve the anatomy of the ear canal and yet totally remove diseased tissue. A mastoidectomy could be carried out and yet, by not destroying the posterior ear canal wall, an open cavity could be avoided. This principle of "leaving up" the posterior ear canal wall has been essentially maintained in most reconstructive ear procedures up to the present day, although there are still differing approaches to this idea. One opinion is that the complete removal of chronic disease requires that the posterior bony canal wall be destroyed at the initial surgery and reconstructed either later in the case or at a second procedure. Proponents of the posterior tympanotomy, or intact-canal wall approach, believe that, in most cases, the wall need never be de-

stroyed. There are also those who still prefer the open cavity as a safeguard against recurrent disease.

Ear surgery thus progressed into the mid-1960s with the ability of the experienced ear surgeon to almost guarantee a safe, healed dry ear. But hearing restoration was still a problem. Based upon the extent of the presenting ear disease, the destruction of the hearing

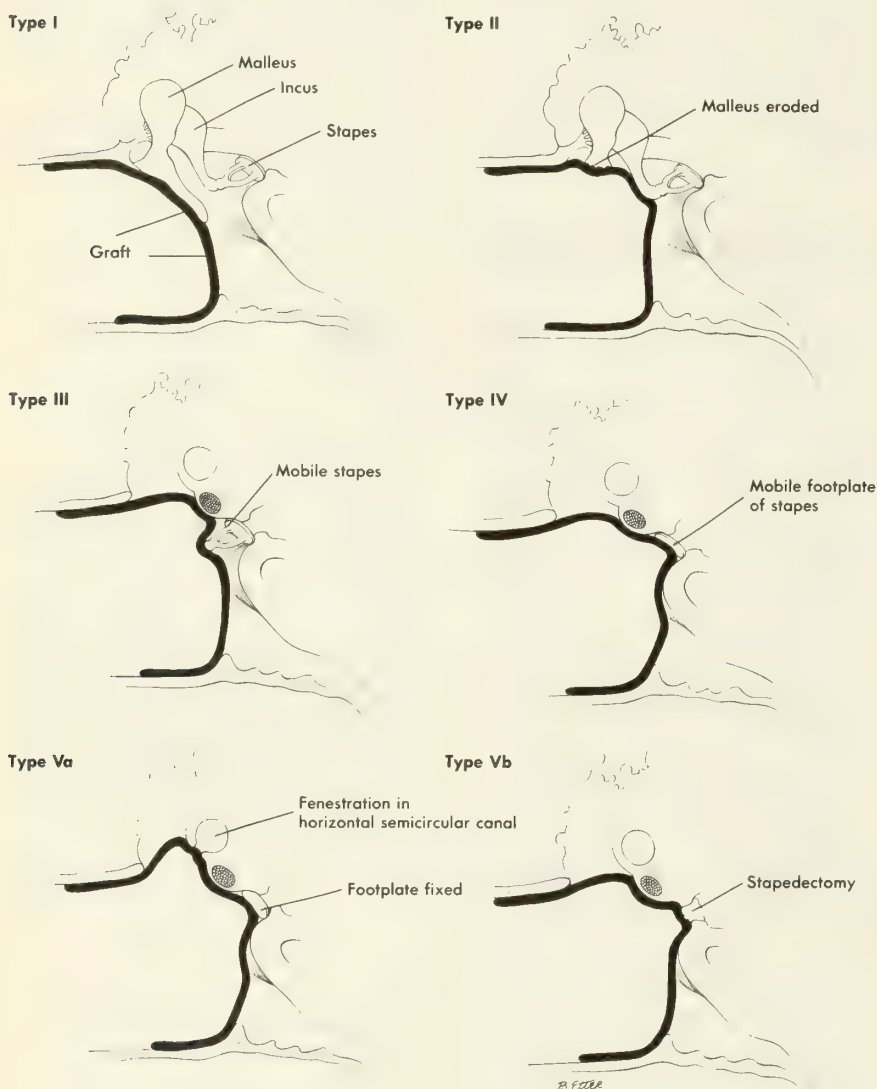
mechanism, i.e., the eardrum and hearing bones, could vary from negligible or partial to total! A vast array of methods and materials were still needed.

Initial attempts at building the ossicular chain involved replacement of missing hearing bones with wires and plastics. As failure rates continued at an unacceptable level, emphasis was placed on the use of au-

togenous^{11,12} and homogeneous^{13,14} ossicles and cartilage.^{15,16,17,18} Methods of rearranging, or interposing this ossicular material were developed. Eardrum grafting modalities, the staging of procedures, and plastic sheeting in the middle ear all improved success rates in ear surgery. The emphasis has now shifted to creating not just a "safe" ear but an ear with serviceable hearing.

With improved hearing now a definitive surgical goal, attention is also directed at two groups of patients whose ear disease previously precluded a satisfactory hearing improvement. They are (1) those patients who had a previous radical mastoidectomy or a previous tympanoplasty with less refined techniques and are burdened with poor hearing and possible residual/recurrent ear disease, and (2) patients with extensive chronic middle ear disease. These patients are those classified by Austin as either a Type B (M-S+) or Type D (M-S-). This classification refers to the presence or absence of the malleus handle (M+ or M-) and stapes superstructure (S+ or S-).

These difficult ears can be reconstructed in one or two-stage procedures by rebuilding the posterior canal wall with homograft bone,²³ homograft dura,²⁴ knee cartilage²⁵ or Proplast.²⁶ Homograft tympanic membranes with or without attached ossicles have been transplanted into radicalized ears as well as Type B and D ears.^{27,28,29} Prostheses such as the Plastipore Total Ossicular Replacement Prosthesis (T.O.R.P.) and Drum to Stapes prosthesis (D.S.) have proven helpful in rebuilding clinically diseased ears as well as ears with previously unsuccessful surgical procedures.^{30,31,32} Adjunct surgical procedures have also been used in attempts to help these difficult ears work more efficiently and not develop later problems. The Wright eustachian tube prosthesis,³³ F.F.F. (formaldehyde-formed-fascia) grafts, homograft fascia or tympanic membranes, all may be used at surgery in rebuilding damaged ears.



Types of tympanoplasty.

Type I: The graft covers the eardrum defect and is in contact with the malleus.

Type II: The graft makes contact primarily with the incus.

Type III: The graft abuts the head of the stapes.

Type IV: The graft contacts the stapes footplate.

Type V(a): The graft abuts a fenestration of the lateral semicircular canal.

Type V(b): The graft is invaginated into the open oval window.

FIGURE 10

CME QUIZ

Urinary Calculi . . .

CONTINUED FROM PAGES 678-680

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.**

ANSWER THE FOLLOWING:

1. Foods with a high oxalate content include all but which of the following:
 - a. Chocolate
 - b. Rhubarb
 - c. Carrots
 - d. Spinach
 - e. Broccoli
2. Radiolucent stones include:
 - a. Calcium stones
 - b. Urate stones
 - c. "Triple phosphate" stones
 - d. Cystine stones
 - e. Oxalate stones
3. The twenty-four hour urine calcium excretion:
 - a. Confirms the diagnosis of hyperparathyroidism
 - b. Is normally in excess of 250 mg/24hrs
 - c. May be decreased by chronic thiazide therapy
 - d. Is largely independent of oral calcium intake
 - e. May be decreased by allopurinol therapy
4. Proposed inhibitors of stone formation include all but which of the following:
 - a. Mucoprotein
 - b. Polypeptides
 - c. Pyrophosphates
 - d. Magnesium
 - e. Citrate
5. Thiazides may be helpful in some individuals with calcium stone formation because:
 - a. They cause a kaliuresis
 - b. They inhibit the proximal resorption of phosphate
 - c. They increase tubular calcium reabsorption
 - d. They elevate plasma renin activity
 - e. They decrease calcium absorption by the small intestine
6. An "alkaline urine" applies to the following except:
 - a. Is helpful in cystinuria
 - b. Increases the solubility of uric acid
 - c. May be observed in certain infections
 - d. Is observed following carbonic anhydrase inhibition
 - e. Can be achieved with d-penicillamine

The following are answers to the CME quiz that appeared in the March 1978 issue of *The Journal*. The article upon which the questions were based was "Platelet Studies as a Measure of Coagulative Integrity of the Surgical Patient," by Robert J. Rohn, M.D., et al.

1. b
2. c
3. a
4. d
5. a

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer sheet for Quiz: (Urinary Calculi . . .)

1. a, b, c, d, e
2. a, b, c, d, e
3. a, b, c, d, e
4. a, b, c, d, e
5. a, b, c, d, e
6. a, b, c, d, e

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

The Division of Postgraduate and Continuing Medical Education must receive your completed, signed application before September 15, 1978, to be eligible for credit for this month's quiz. Answers to the quiz will appear in a later issue.

The Treatment of Urticaria

JERE D. GUIN, M.D.
Kokomo

Urticaria is a histologically mild form of vasculitis that can be produced by several different mediators of inflammation. It has many different etiologies. Consequently, the treatment of the disease will depend upon the etiology and the particular mediators involved.

The approach I shall present is by no means a complete approach but rather it should be regarded as a starting point. Urticaria has been divided arbitrarily into acute and chronic urticaria depending upon the duration of the disease. Management, however, is somewhat similar.

The obvious treatment is the determination of the cause of the condition and the elimination of it, if possible. The pathophysiology of mast cell degranulation and the breakdown of histamine can be used to advantage in handling the patient with histamine-mediated urticaria. Nonspecific factors causing vasodilatation are to be minimized and the use of oral antihistaminics and tranquilizers and/or sedatives are helpful in controlling the symptomatology.

Dr. Guin, a diplomate of the American Board of Dermatology, is a clinical assistant professor of dermatology at Indiana University School of Medicine. This article is based on his presentation at a workshop on dermatologic treatment sponsored by the I.U. School of Medicine and held at St. Joseph Hospital, Kokomo, Nov. 9, 1977.

The initial step in the workup is to take a detailed urticarial history. This can best be done by using printed forms with questions that can be answered yes or no. In this manner, the clinician can assess areas of investigation that are most likely to be fruitful. More details in significant areas can then be obtained in person. This questionnaire definitely should include medications taken at present and in the recent past, and previous allergies (including drug allergies). A history of penicillin allergy, for example, would alert the physician to the possibility of allergy to penicillin in dairy products. Physical findings can also be important. The presence of arthritis or leukocytoclastic angitis would suggest an immune complex problem. Lists of questions can also be developed to remind the patient of items one might tend to forget. It can also be used to determine an association with yeast, dyes, etc. in food.

The general medical history is also useful, especially in chronic urticaria. Probably the most fruitful part of the history in chronic urticaria patients, however, is the emotional history. A sizeable number of these patients have elevated anxiety scores on the MMPI examination. Frequently, while taking a history, it is possible to discover sources of anxiety that may have preceded the onset or an exacerbation

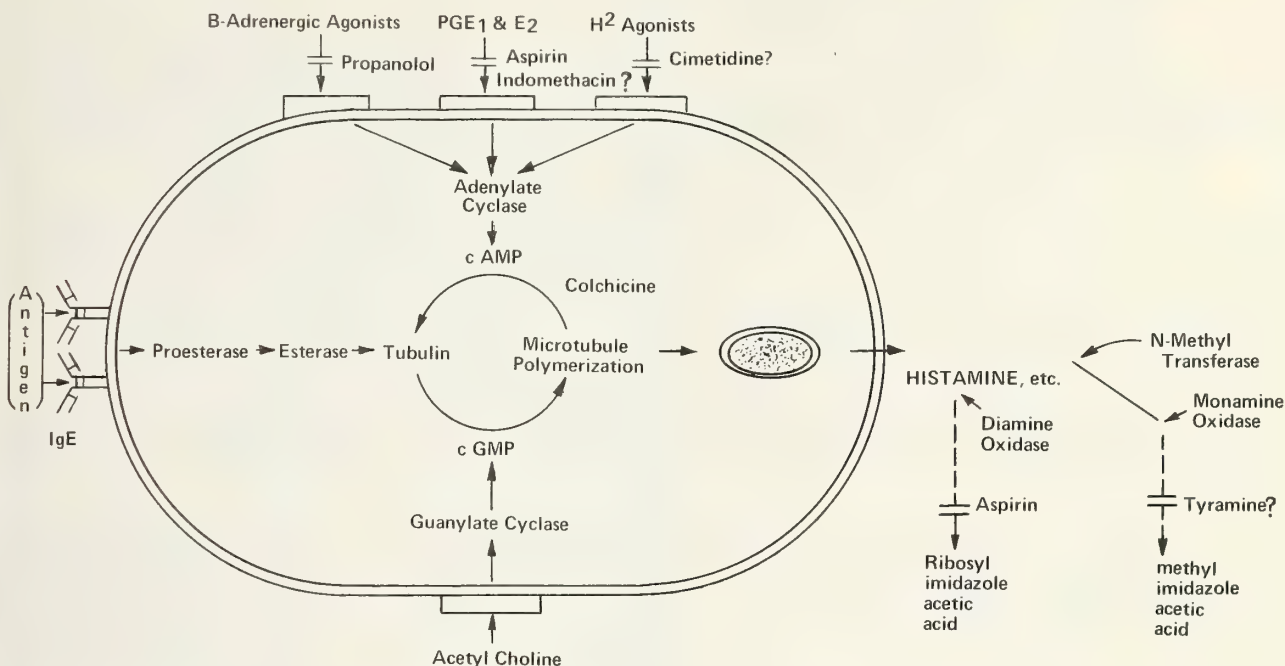
of the eruption. Understanding and reassurance at this point definitely have therapeutic value in the average patient with chronic urticaria. Sometimes, other diagnostic procedures such as a CBC, chemistry screen, complement levels and a candidal scratch test may be of value.

Many everyday occurrences can be detrimental to the course of urticaria. Anything producing vasodilatation will aggravate the condition. This would include alcoholic beverages, exercise, fever, hot baths, etc. A warm electric blanket at night can result in prominent urticaria in the morning.

A number of pharmacologic agents increase mast cell release in the laboratory (*Figure*) and seem to do so clinically. Some drugs have a nonspecific histamine-releasing effect. Examples are codeine, morphine, hydralazine, thiamine and stilbamidine, but the list is much longer.

An important drug to be excluded in the urticarial patient is aspirin. Wintergreen flavoring, other salicylates and tartrazine may also be aggravating. Diets minimizing such items are available and can be used profitably. Prostaglandin E-blocking drugs such as indomethacin have been noted to aggravate urticaria in my practice and this is predictable. Tyramine in certain foods has also been found to ag-

A CONCEPT OF MAST CELL RELEASE IN URTICARIA



gravate urticaria. This may be due to a release of alpha-adrenergic agents peripherally. Receptors for these agents are present on tissue mast cells but not on basophils. One would also predict that propanolol and cimetidine may be aggravating because of their effect on cyclic nucleotide levels.

Histamine is catabolized in tissue by two pathways. Monoamine oxidase is required in one pathway, which may be another reason tyramine seems to adversely affect some patients with urticaria. The other pathway can be blocked at one point by aspirin. While the first pathway is more important in the skin of man, catabolism of histamine will increase via either pathway if the other is blocked. It should not be difficult to obtain interference in both pathways simultaneously, but the body has a remarkable capacity to degrade histamine.

Symptomatic relief can be obtained in most patients with the use of oral antihistaminics (H_1 blockers). Hydroxyzine is probably the drug of choice for most patients with chronic urticaria. Atarax® must be used as the 10 mg. tablet or

the pediatric syrup since other convenient dosage forms contain tartrazine. Occasionally, phenobarbital is helpful in persons who do not improve on hydroxyzine or who do not tolerate it. Cyproheptadine can be used along with hydroxyzine but one has to monitor drowsiness with both drugs. Methdilazine and carbinoxamine are sometimes tolerated in patients who experience this symptom at effective dosage levels of other antihistaminics. Epinephrine is used chiefly in acute attacks and can be life-saving when angioedema occurs in the throat and/or larynx. Corticosteroids have a place in the treatment of acute episodes of known cause, e.g., drug eruptions. They are not indicated in the usual patient with chronic urticaria.

In summary, one approaches the treatment of urticaria by attempting to eliminate the cause, by manipulating the physiology of histamine release and by controlling vasodilatation. Each patient must be evaluated individually on the basis of his history as well as his physical, emotional and laboratory findings. Antihistaminics and especially hydroxyzine are useful in controlling the symptomatology.

ADDENDUM

A letter from Roerig, a division of Pfizer Pharmaceuticals, dated Apr. 21, 1978, states that only the 50 mg. tablet of Atarax® contains tartrazine (FD&C Yellow #5). As a matter of high priority, Roerig is removing tartrazine from all of their pharmaceutical products, a task they hope to have completed by the end of this year.

REFERENCES

1. Warin, Robert P. and Champion, Robert H. Urticaria. Philadelphia, W.B. Saunders, Co., 1974.
2. Monroe, Eugene W. and Jones, Henry E. Urticaria (Review article). *Archives of Dermatology* 113:80-90, 1977.
3. Beaven, Michael A. Histamine in Physiology in Medicine. *New England Journal of Medicine* 294:30-36, 320-325, 1976.
4. Kaliner, Michael. Human lung tissue and anaphylaxis. Evidence that cyclic nucleotides modulate the immunologic release of mediators through effects on microtubular assembly. *Journal of Clinical Investigation* 60:951-959, 1977.
5. Beaven, Michael A. Histamine and its participation in dermatological disorders. *Progress in Dermatology* 11(4,5):15-22, 23-30, 1977.

CANCER CORNER

EVERY PHYSICIAN'S OFFICE—
A CANCER DETECTION CENTER

Help Your Patients Quit Smoking

You are the key influence in persuading your patients to quit smoking. You can help us achieve our five-year goal to reduce smoking by 25% among adults and by 50% among young people. A recent Gallup survey revealed that 71% of patients who smoked a pack a day or more would quit smoking cigarettes if their physicians urged them to do so. The survey also showed that more younger than older smokers would accept their physician's advice.

Three minutes of your time may be all it takes. What better investment could you make? It has been proven that 30 seconds of a physician's time is enough to get 10% of patients who smoke to quit. With just a little more time and effort, figures have been reported as high as 40%.

Follow the American Cancer Society's three-point program:

- Urge all patients who smoke to quit.

Ask them about their smoking habits (current smoking status, smoking history and previous attempts to quit). Point out smoking's harmful effects on health, particularly on the respiratory and cardiovascular systems. Be frank. Tell patients what their chances are of surviving lung cancer.

Tell them that smoking is as important a risk factor in heart disease as high blood pressure and cholesterol.

Present a strong statement about quitting! Tell them that they'll begin to feel the benefits very soon after they've quit smoking, that any damage to their bodies, if no disease is present, will begin to be repaired immediately.

- Give your patients the assistance they need.

Although quitting smoking may be easy for some people, it is difficult for most. And no single approach will work for everyone. Only by understanding your patients can you prepare them for quitting and provide effective advice.

We've created a number of aids that will help you help your patients. This **Help Quit Kit** was specially designed by physicians for physicians to use in their offices.

In the pockets of the kit you will find a number of effective aids that will help you get your quit smoking message across.

Ask your patients to call the local ACS unit for further help in breaking their smoking habit.

- Follow-up to help your patients stay quit.

Maintenance is most important for long-term success in quitting. Keeping in touch with patients shows that you really care and offers support at a crucial time in the quitting process.

Follow-ups can be either by telephone or mail, although personal contact is best. Your office nurse or receptionist could be of invaluable assistance here. A minimal procedure is to ask selected patients to call you if they get the urge to smoke. Teaching your patients how to relax or meditate can also help them stay quit.

And don't forget your local ACS unit is ready and willing to help.

The above mentioned **Help Quit Kit** is a program available for helping physicians to help patients stop smoking. Contents of the kit include:

Waiting Room Sign: "To my patients: Quit smoking now. Before you have to quit. I have had to tell many of my patients to give up smoking because it was damaging their health. I would much rather you quit before your health is damaged. I know it is not easy to give up smoking, but I would like to help you try. Talk to me about it today or make an appointment for a more convenient time."

Your patients probably think more seriously about their health in your waiting room than at any other time or place. Set this sign up on a table or hang it on a picture hook. Give your patients something constructive to think about, and the offer of a helping hand.

"Smoker" Labels: As a reminder to yourself that a patient has a smoking problem, you may want to stick one of these "smoker" labels on his or her record. You may even want to do this in the patient's presence, to underscore the fact that you consider the smoking habit a significant aspect of the medical profile.

Desk-top Sign: "For your health and my peace of mind: Let me help you quit smoking. It may not be as hard as you think."

This message, placed conspicuously in your consulting room, will serve notice to your patients of your concern about the smoking habit and your desire to help each smoker kick it.

Prescription Pads: Prescribe the simplest and least expensive medicine of all, "Quit Smoking." In the space provided, you may want to add some suggestions such as, "Get an I Quit Kit," "Talk to an ex-smoker," or "Join a Quit Smoking Clinic."

Posters: Cigarette advertisements abound in magazines, in trains and buses, on billboards along the highways. Put up your own quit-smoking advertisement in a prominent place in your waiting room or consultation room. It pays to advertise good health.

Patient Take-home Literature: To help reinforce your advice to your patients, we've included several copies of a small piece of literature that sums up the most important current facts on smoking and health. Additional materials are available from your local ACS unit at no charge. Just give them a call.

COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.

COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.

Simple drops of water
help make COLACE®
the most widely used
stool softener.

COLACE

dioctyl sodium sulfosuccinate

MeadJohnson

PHARMACEUTICAL DIVISION

Radiology

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

With the growing use of ultrasound in our diagnostic procedures, there is some concern that the word "radiology" is inappropriate for a specialty where x-rays, nuclear medicine, and ultrasound are all used to diagnose and treat disease.

Some favor use of the term "diagnostic imaging" as a substitute for radiology. Diagnostic imaging may be satisfactory, but it is a longer term; it takes two words and a total of seven syllables to carry the idea of the old word "radiology," a five syllabled, one word term.

I think that the word "radiology" is still appropriate for the use of ultrasound diagnostic techniques in addition to x-ray or nuclear medicine techniques. For after all, radiology means the use of radiation to diagnose and treat disease, and ultrasound is just another part of the electromagnetic spectrum of radiation. To be sure, the wave lengths may be somewhat longer than what we are accustomed to with x-rays or nuclear medicine, but the physician who uses ultra-

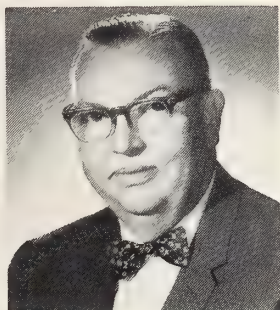
sound is still using radiation to diagnose disease, and this is what the game is about.

The radiologist uses other sources of radiation such as the light on the view box to illuminate his films or light from an overhead lamp to view his Polaroid prints. He uses his voice to dictate reports; his voice is sound, a slower moving part of the electromagnetic spectrum, but still a form of radiation. He has been using sound and illuminating light for years in the practice of radiology, and the use of these slower moving waves has not caused him to change the name from "radiology" to some other term in the past. Why is there need for a change now?

I don't think the introduction of ultrasound makes it necessary to change from the term "radiology" to a new term. It is still radiation, and the person who practices it can be considered a radiologist rather than a diagnostic imager.

I see no need to change from radiology or radiologist.

Jim Waggener Memorial Fund



The Indiana State Medical Association has established a memorial fund for James A. Waggener, honorary member of the Association and Executive Secretary for ISMA for some 27 years.

The Jim Waggener Fund will reside in The Indiana Medical Foundation, Inc., an arm of the Association that is

devoted to financial support of THE JOURNAL and continuing medical education. Both projects were Jim's favorites.

Contributions to the Fund and to the Foundation are tax deductible.

All members of ISMA and all friends of Jim Waggener are invited to contribute to the Jim Waggener Fund in memory of his long years of dedicated service to the medical profession. The address for contributions is 3935 N. Meridian St., Indianapolis, Ind. 46208.



HE SCALPEL AND THE PEN

Tobias George Smollett, 1721-1771

RODNEY A. MANNION, M.D.
LaPorte

*"Where, where was Roderick then!
One blast upon his bugle horn
Were worth a thousand men!"—*

THE LADY OF THE LAKE, BY SIR WALTER SCOTT
(1771-1832)

*"Obstinacy in a bad cause is
But Constancy in a good."—*

THE RELIGIO MEDICI, BY SIR THOMAS BROWNE
(1605-1682)

Sir Walter Scott was Scotland's greatest novelist and Dr. Tobias Smollett was the first. He died the year Scott was born. The above quotation from Scott epitomizes Smollett's idealism and coincidentally concerns a hero—Roderick, from Smollett's autobiographical novel, "Roderick Random." The second quotation is from William Osler's favorite medical philosopher and defines Smollett's mode of behavior in pursuing these ideals for reforming the brutal manners of the 18th Century. He spent his literary life, although frequently concerned with mere financial survival, denouncing the social conditions of the times, foreshadowing Charles Dickens in this effort.

There are said to be four originators of the English novel. These are Fielding (a journalist and magistrate), Richardson (a printer), Sterne (a would-be curate) and Smollett, the surgeon-author and subject of this essay. He was born at Dumbartonshire and was baptized March 21, 1721. The roots of the Smollett

family were established for centuries in this region and indeed are still so today. Some branches of the family were financially well off, but this was not the case with his father and Tobias was apprenticed to a Glasgow surgeon in 1736. He also spent some time at Glasgow University. Poverty forced him to join the Royal Navy as a surgeon's mate in 1740. He was deeply affected by his navy experiences, especially regarding Britain's abortive attempt to take the Spanish Mediterranean city of Cartagena. He wrote the first realistic account of the horrors of naval warfare. His view from the surgeon's cockpit with its blood and immediate amputations was less than heroic. Most of his fiction is imbued with some nautical sense, particularly the novels "Roderick Random" and "Peregrine Pickle."

Smollett was venomous at times and this was partly occasioned by a feeling of alienation at being an impecunious Scot living in England. After all, to paraphrase his contemporary, Dr. Samuel Johnson, "Much can be made of a Scotchman if he be caught young." Acceptance of the emotional Celt, in spite of a similar religious opposition to the Papacy, came later (if at all) to the Anglo-Saxon consciousness. The "Act of Union" of 1709 was in recent memory in Smollett's time. Scotland had realized that further resistance was futile and England knew it. The Scottish nationalistic spirit emerged in Dr. Smollett's poem of 1746, "The Tears of Scotland," where he laments for the dead of the battle of

Culloden Moor, killed in Prince Charles Stuart's uprising of the previous year. He wrote:

*"While the warm blood bedews my veins,
And unimpair'd remembrance reigns,
Resentment of my country's fate,
Within my filial breast shall beat,
And, spite of her insulting foe,
My sympathizing verse shall flow . . .
Mourn, hapless Caledonia, mourn
Thy vanish'd peace, thy laurels torn."*

He also wrote an unactable play called "The Regicide" and two of his first books of critical satire called "Advice" and "Reproof" represented a fearless, although imprudent, diatribe against the grafters, cruel jailors, homosexuals in high office and generally the aristocratic, nepotistic English establishment of those days. Powerful enemies were the result and after a libel suit some years later, he spent six months in prison.

After resigning from the Navy, he tried to set up a small medical practice in London in 1744. It was only after the initial success of "Roderick Random" in 1748 that he gradually lived by writing. He obtained an M.D. degree from Marischal College in 1750. Reading him today gives an insight into 18th Century medicine and surgery. Blood letting, justified by the humoral theory of physiology, was the vogue and Smollett would perform this for many conditions including "plethora." Cathartics or "Clysters" were common prescriptions. The poor conditions in the sick bay of a gun ship on active duty are described: ". . . Here I saw about 50 miserable distempered wretches, suspended in rows, so huddled one upon another, that not more than 14 in. space was allotted for each with his bed and bedding; and deprived of the light of day, as well as of fresh air; breathing nothing but a noisome atmosphere of the morbid streams exhaling from their own excrements and diseased bodies, devoured with vermin hatched in the filth that surrounded them . . ." Smollett realized the virtues of good ventilation.

Another excerpt from "Roderick Random" describes a case of schizophrenia where a woman thinks she is at times a cat, a hare and once she: ". . . prophesied the general conflagration was at hand, and nothing would be able to quench it but her water, which, therefore, she kept so long that her life was in danger; and she must needs die of the retention . . ." and so on until they had to kindle a bonfire in order for her to urinate! A graphic description of psychogenic urinary retention. Those interested in medical lore will find much



today in reading Smollett and might be pleasantly surprised by the familiarity of certain methods. The popular procedure then for burns was a salt water application that only increased the inflammation of the tissues, whereas Smollett recommended the use of emollients. Amputation, because of sepsis, was the prime surgical technique for extremity wounds; this would remain so for 100 years until the age of antiseptic surgery. An interesting misapprehension on Smollett's part concerns his obvious belief that syphilis, as seen in a prostitute, was cured "at the expense of her nose." This is a reference to the saddle nose of tertiary lues.

His examination at Surgeon's Hall to secure qualifications as a surgeon's mate is cogent testimony regarding the state of the medical art in 1740. He states that "Mr. Snarler" yelled at him so that he was "scarce able to stand." Then a "plump gentleman" examined him on the operation of trephining by referring to a skull on a table before him. He acquitted himself well. Then a "wag" asked about amputation in a man "with his head blown off." He replied that he had never seen a cure propounded in any treatise of surgery. He was then asked about bleeding a plethoric patient who had a fall. The wag said: "What, before you had bound up the arm?" But he was passed to the next man who asked "with a pert air" the method of cure for wounds of the intestine. Roderick recited the method of cure and was heard to an end but was met with a supercilious smile and the examiner said, "So you think by such treatment the patient might recover?" He told him that he saw nothing to make him think otherwise. "That may be," resumed he, "I won't answer for your foresight; but did you ever know of a case of this kind to succeed?"



He was about to tell him that he had never seen a wounded intestine but was stopped. His interrogator said, "Nor never will. I affirm that all wounds of the intestine, either great or small, are mortal." Then ensued a great argument among the examiners and one said, "Sir, excuse me, I despise all authority . . . I stand upon my own bottom." The altercation continued and one antagonist cried, "A fig for reason . . . I laugh at reason, give me ocular demonstration." Then the chairman called for silence and ordered Roderick to withdraw. The proscription that the peritoneum was inviolate remained in force through the 18th Century and for more than half the 19th Century. Contentions between the pragmatic and academic surgeons were prevalent even 200 years ago just as today.

Smollett must have been a complete student, especially of languages, in spite of the paucity of his university education, because, among his other creative works, he translated Alain René LeSage's "Gil Blas" in 1749 and the, for many years, definitive translation of Cervantes' "Don Quixote" in 1755. He tried his own hand at Quixotic literature with "The Adventures of Sir Lancelot Greaves" in 1760 and 1761. Among his fictional works is "The Adventures of Ferdinand, Count Fathom" (1753) and finally what is purported to be his finest work, "The Expedition of Humphrey Clinker" (1765). He was an inveterate traveler and

wrote well received travel books, notably "Travels Through France and Italy" (1766). Finally he composed a sketchy "History of England" (1757-65) as a hack effort for remuneration. It was criticized for incompleteness but had some incisive commentary.

The novel, as an art form, was in swaddling clothes in the 1700s and Smollett did much to mature the idea of a complete prose story in one volume. However, he relied mainly on the travel format with his protagonists achieving their dramatic interplay in the stages of an actual journey. Thus these efforts are called "picaresque" novels. He was the master of this form. A relatively recent critic, writing in 1947, told about Smollett's limitations: ". . . Something is arrested in the growth of his robust mind; as a novelist he remains the portrayer of the outside, rarely able to get away from physical externals or to develop from that starting point into something but physical caricature." This same commentator found Smollett interesting reading after 200 years because he lacked the unforthrightness of the Victorians and was, in many ways, very literal and truthful. For this reason, Smollett makes appealing reading today. Perhaps the same can be said regarding the writing of Henry Fielding as shown by the popular film "Tom Jones," adapted from that author.

Again from "Roderick" is an example of Smollett's straightforward narrative. "Strap," Random's right hand man and loyal lieutenant, is complaining, upon their arrival in London: "We have brought our pigs to a fine market . . . God send us well out of this place; we have not been in London eight and forty hours and I believe we have met with eight and forty thousand misfortunes. We have been jeered, reproached, buffeted, pissed upon, and at last stripped of our money; and I suppose by and by we shall be stripped of our skins . . ."

He began as a reformer and used satire, irony, witty riposte and even denunciation in his effort to expose the ills of his time but gradually a negative tendency in his personality, coupled with declining health, made "Toby" Smollett (as his enemies termed him) almost a pessimist. Nevertheless, he was ostensibly married happily (to Anne Lascelles, a Jamaican lady, in 1747) and his correspondence shows him to have a loving family and a circle of close friends. He depicts "Roderick" as having the symptoms of a disease resembling yellow fever, so perhaps he suffered the same malady himself while engaged as a naval surgeon. He had a wasting disease some years

later and, as so many Englishmen before and since, repaired to Italy to regain his lost health. He did not make it back home and died in Leghorn Sept. 17, 1771. To summarize his traits a quotation from his own writing will give an insight. "... But my heart was so much steeled . . . by pride and resentment, which were two chief ingredients in my disposition. . . ." But it may be said that in his heart he was sensible to the social problems of humanity and was moved to remedy these evils where many a lesser man was only complacent.

Smollet's writing was "salty" and tended to offend prudish Victorian mores. His work is reminiscent of the French doctor-writer of 200 years before—Francois Rabelais. Both were exponents of the genito-urinary and gastrointestinal genre of humorous composition, although Rabelais was actually vulgar. A case might also be made for Smollett's essentially 20th Century modernity; his frank depiction of human physiology is unlike his immediate successors such as Scott, Dickens and others. In a sense, the Victorian Age is isolate in its strict literary sexual taboos and quite out of the main stream of English literature beginning for instance with Chaucer, progressing to Shakespeare and coming on to, perhaps, James Joyce.

Sir Walter Scott included a classical essay on Smollett in his "Lives of Eminent Novelists and Dramatists" wherein he scored against him for his pruriency and lack of gentle restraint in writing. In many ways Smollett makes easier reading today than does Scott who is the romantic, while Smollett is the realist. Although the Smolletts were traditionally Presbyterian in religion and Whig in politics, Tobias gradually tended to favor the Established Church and Toryism, although actually practicing neither. This is the final inconsistency in his character, that this man of the acid, reforming pen would gradually advocate conservatism. However, perhaps he should not be judged by the usual standards but only by the measure of truth for which he battled in his

lifetime. Many of the abuses which he opposed have already passed from the European scene and a seemingly full circle achieved with the welfare state in Britain. If the doctor were alive today, what a satire he could make of that state of affairs!



BIBLIOGRAPHY

- Encyclopaedia Britannica, 20:702, 1971.
- Colliers Encyclopedia, 17:660-661, 1958.
- The Cambridge History of English Literature. Edited by Sir A. W. Ward and A. R. Waller, Vol. X: "The Age of Johnson," pp 36-45.
- As I Please, Book III, 1943-1945, Collected Essays, Journalism and Letters of Geo. Orwell. Harcourt, Brace and World, Inc., N.Y., 1968.
- Tobias Smollett, Traveler-Novelist, by Geo. M. Kahrl, Univ. Chicago Press, Chicago, 1945.
- Lives of Eminent Novelists and Dramatists, by Sir Walter Scott. Frederick Warne and Co., London and New York, 1887. pp 437-67.
- Tobias Smollett, Doctor of Men and Manners, by Lewis Mansfield Knapp, Princeton Univ. Press, Princeton, New Jersey, 1949.
- The Works of Tobias Smollett, Vol. V., Bigelow, Brown and Co., Inc., New York.
- The Miscellaneous Works of Tobias Smollett, M.D. with Memories of His Life and Writings by Robert Anderson, M.D., 2nd Edition, Enlarged, Vol. III, Mandell and Son, Edinburgh, 1800.
- Tobias Smollett, Peregrine Pickle. Introduction by Walter Allen, Everyman's Library, Nos. 838-9, J. M. Dent and Sons, Ltd., New York, London, 1956.

ISMA ANNUAL MEETING

October 22-25 · Clarksville

FUTURE FILE

Polytomography of the Temporal Bone

The 19th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, September 23-24. As an organization accredited for continuing medical education, the Wright Institute of Otology, Inc. certifies that this continuing medical education activity meets the criteria for 12 credit hours in Category 1 of the Physician's Recognition Award of the AMA.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Fee for the course is \$250. Inquiries should be directed to:

The Wright Institute of Otology, Inc.
Community Hospital of Indianapolis
1500 North Ritter Avenue
Indianapolis 46219

'Exam Cram' Offered

The Indiana Academy of Family Physicians will repeat a course on Patient Management Problems: "Exam Cram," at the Airport Holiday Inn, Indianapolis, Aug 21-24. The course is designed to assist either the established, practicing physician or the newly graduated resident in his last-minute review for the American Board of Family Practice certification or recertification examination. The first course of this type was conducted June 23-26.

Thyroid Disease Workshop Set

A "Workshop on Thyroid Disease" will be sponsored by the American Thyroid Association at the Copley Plaza Hotel in Boston Nov. 5-7. The two-day program is designed for internists, family practitioners, surgeons and obstetricians who do not have subspecialty training in thyroidology. For program and registration information write to WT Registration, Center for Continuing Education, 1307 E. 60th St., Chicago 60637.

Infant and Child Feeding Symposium

An international symposium on infant and child feeding will be held at Michigan State University, East Lansing, Oct. 15-19. Internationally recognized authorities will review the latest on nutrient requirements for growth and development and many other relationships between nutrition and socio-economic factors. For further information write to Dr. Gilbert A. Leveille, The Kellogg Center, Room 23, East Lansing, Mich. 48824.

Ear Disease Symposium

A symposium on "Ear Disease and the Primary Care Physician" will be conducted at Community Hospital in Indianapolis Oct. 21. Offering eight AMA Category 1 credit hours, subjects will include basic anatomy and physiology of the ear, basic office audiometry, electro-nystagmography and polytomography of the temporal bone, otitis media, pediatric otology, facial palsy, sudden hearing loss, the dizzy patient, otosclerosis, systemic disease in the ear and tumors of the ear.

Fee for the course is \$75. For more information, contact the Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis 46219, phone (317) 353-5679.

Child Abuse Conference

A conference on child abuse will be conducted Aug. 25-26 by the Indiana Chapter of the National Committee for Prevention of Child Abuse at the Brown County Ramada Inn and Convention Center, Nashville. Registration fee is \$30 for members and \$40 for others if registration is prior to Aug. 7—after that time the fees are \$35 and \$45. Ray Helfer, M.D. and Dr. Norman Polansky, both of whom are noted authorities on the subject, will head the many experts on the program. For further information and for registration write the Indiana Chapter, NCPCA, P.O. Box 1226, Columbus 47201.

Pediatric Care Symposium

The I.U. School of Medicine and the James Whitcomb Riley Hospital for Children will sponsor the sixth annual pediatric surgical fall symposium Oct. 4-5 at the Hyatt Regency Hotel, Indianapolis.

Topics for the symposium, called "Progress in Pediatric Care," will include neonatal aspiration, oxygen therapy, hematuria, tracheal stricture, x-ray evaluation, spinal deformities, anesthesia, juvenile diabetes, leukemia, Wilms' tumor, intussusception, seizure disorders, pediatric cardiology, gastroesophageal reflux, esophageal atresia, and ophthalmologic, dermatologic and urologic disorders.

The symposium is approved by AMA for 13 hours of post-graduate credit.

For information, contact the symposium director, Jay L. Grosfeld, M.D., surgeon-in-chief, James Whitcomb Riley Hospital for Children, Rm. K-21, 1100 W. Michigan St., Indianapolis 46202.

Indiana University CME Offerings

Sept. 6: Pediatrics for Primary Care Physicians (Kokomo);

Sept. 8-9: Pediatric Ophthalmology (Indianapolis);

Sept. 20: Ophthalmology for Primary Care Physicians (Kokomo);

Sept. 27-29: Advanced Echocardiography (Indianapolis);

Sept. 29: Epilepsies (Indianapolis).

Doctor:

If you think Purepac
is a quality generic,

You're Right!

If you think Purepac
is expensive,

You're Wrong!

Purepac's line of over 300 generics is one of the lowest priced brands available to pharmacists. . . significantly lower than most generics from a brand name company.

Sometimes, when comparing specific prices, you may find a Purepac generic costs a fraction of a cent more per tablet or capsule than generics available from small generic manufacturers or mail order suppliers.

Why does this fraction of a cent difference occur? Because Purepac

- manufactures most of its major generics,
- provides product liability protection,
- has its own quality control laboratories
- tests its products to insure you consistency in size, shape, color and product uniformity.



PUREPAC

Elizabeth, NJ 07207

AMERICA'S LEADING NATIONAL BRAND OF GENERICS

Available in Indiana at



BOOK REVIEWS



Reviews in Perinatal Medicine, Vol. 2

Editors: Emile M. Scarpelli, M.D., Ph.D., director, Pediatric Pulmonary Center, Albert Einstein College of Medicine, Bronx, N.Y.; and Ermelando V. Cosmi, M.D., L.D., director of Obstetrical Anesthesiology, University of Rome, Rome, Italy. Raven Press, 1140 Avenue of the Americas, NYC 10036, 1978, 383 pages plus index of 11 pages. The editorial board consists of 15 members from 12 different countries, and there are 22 contributors from 8 different countries. \$27.50.

This is the second of a series of annual publications with "international perspective" and "in-depth coverage of basic science and clinical medicine." And in-depth coverage it is—too deep to cover in a book review, but nevertheless worthy of being brought to the attention of obstetricians, pediatricians, and generalists with interest in these fields.

The chapter titles will illuminate the character and scope of the work and are as follows: Diabetes in Pregnancy, Diagnostic Cardiotocography, Preterm Labor, Paracervical Blockade During Labor, Applications of Radioimmunoassay in Perinatal Medicine, Prostaglandin Inhibitors in the Perinatal Period, Phospholipid Metabolism in Perinatal Lung, Bilirubin Binding by Plasma Proteins: A Critical Evaluation of Methods and Clinical Implications, Neonatal Oxygen Transport, Nonshivering Heat Production in the Newborn.

There are extensive bibliographies (to be anticipated in in-depth scientific reporting and

analysis), the total number of references being 1,448, with 324 for lung phospholipids and 230 for diabetes of pregnancy. The illustrations consist of charts, tables and diagrams, all clearly printed and labelled. The typography is well-designed and pleasing to the eye, albeit rather small type. But this is being observed more and more in recent publications—like the dollar, print type shrinks with inflation.

Each chapter has its own conclusion, and as a sample of the down-to-earth character of the researchers, that on diabetes in pregnancy includes: "Ideally, every pregnancy in a diabetic woman should be planned. Although evidence is lacking, there is good reason to believe that meticulous metabolic control during the periconceptional period and the first months of pregnancy could reduce the incidence of congenital malformations." Again re preterm labor: "Preterm labor occurs in little more than 5% of births, yet it causes 85% of the early neonatal deaths . . . The situation is complicated . . . much work is needed to clarify the situation and improve management further." And one more: "Measurement of the intravascular albumin compartment alone may not be adequate to assess the risk for bilirubin-related brain damage. Clinical judgment must be used in conjunction with any laboratory tool."

And this from the basic science boys! Truly, we must be making progress. This should be a splendid source for residents in obstetrics and pediatrics to have at hand.

A. W. CAVINS, M.D.
Gynecologist
Terre Haute

INDIANA MEDICAL BUREAU

1010 East 86th St.—72 Winterton

Indianapolis 46240

844-7933

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 26th Year of Service

BOOK REVIEWS

SI Units in Medicine

An introduction to the International System of Units with conversion tables and normal ranges. Herbert Lippert, M.D. and H. Peter Lehmann, Ph.D., 1978, Urban & Schwarzenberg, 7 E. Redwood St., Baltimore, Md. 21202, 211 pages, \$14.50.

The International System of Units (SI) is presented as a "logical, simplified, and modernized version" of the metric system. It was established in 1960 by the 11th General Conference of Weights and Measures, and in 1977, the World Health Organization recommended the adoption of the system by the medical community throughout the world.

There has been widespread varied response to the adoption of SI units in medicine by national and international organizations. In the United States, there has been no consensus among the national organizations in the field of medicine for the adoption of SI. Some medical organizations have supported its use for reporting data in their field, but often with

some reservations and alternative recommendations.

The changes proposed by the system are far-reaching: the introduction to this text states, "It would be naive to think that such fundamental changes can be made without some difficulty and without a certain risk to the patient," and further that "the introduction of the International System of Units has provoked a worldwide storm of indignation in the medical profession."

This text presents an introduction, legislation covering the International Systems of Units, tables and explanatory notes for their use, and appendices. It also contains references and an index. The book has a looseleaf, plastic binding. 211 pages, and is priced (somewhat surprisingly) at \$14.50. It is recommended for physicians who would like to become familiar with the International System of Units, which may or may not represent the wave of the future.

W. D. SNIVELY, JR., M.D.
Internal Medicine
Evansville

BE THE
DOCTOR
YOU WANT
TO BE
IN THE NAVY

For more information,
call toll-free 800-841-8000
(in Georgia: 800-342-5855)
or see your local
Navy representative.

When it comes
to nuclear training,
no one can give you
a better start.

In the Navy, it's not just a job.

It's an adventure. For more
information, call toll-free 800-841-8000
(in Georgia: 800-342-5855) or see your
local Navy representative.

NEWS NOTES

Library Conference Slated

The Governor's Conference on Libraries and Information Services will meet Aug. 11 - 13 at the Atkinson Hotel, Indianapolis. Delegates to the conference will include lay leaders, users and potential users of library services, librarians and library trustees. The general sessions and exhibits will be open to the public. Governor Bowen will be the keynote speaker. The event is preliminary to the September 1979 President's White House Conference on Library and Information Services.



U.S. NAVY PHOTO

Hoosier Invents Gann Medi-Pac

Larry Gann of Evansville (above), a Navy hospital corpsman stationed in San Diego, displays the Gann Medi-Pac he designed while serving aboard the carrier, USS Coral Sea. First aid items are carried in the pockets, which are sewn on a standard flight deck life preserver. He developed the idea after fumbling through a canvas bag for supplies while treating an injured sailor on the carrier's flight deck. The Navy is testing 14 of the vests on seven types of ships to see how well they work.

County Establishes Grant Program

The St. Joseph County Medical Society has established an education foundation to provide scholarships to medical students from the county. The action was made possible by a bequest from Dr. F. R. Nicholas Carter, a former county and South Bend health officer.

Quick Help for Snake Bites

Virtually all of the exotic antivenin available for therapeutic use in the United States is located in the major zoological parks. The American Association of Zoological Parks and Aquariums (AAZPA) maintains a 24-hour-a-day Antivenin Index Center in Oklahoma City, Tel: (405)-271-5454. When calling for the location of the antivenin supply nearest you, give the scientific name and the common name of the snake involved. The center will provide the emergency phone numbers and names of key personnel for obtaining the proper antivenin.

Medal of Merit to Governor

Indiana Governor Otis R. Bowen, M.D. has been named the first recipient of Valparaiso University's new Medal of Merit. Together with Lowell Thomas, Gov. Bowen is an honorary co-chairman of the university's program to raise \$28 million in support from outside sources by 1980.

Elections

Dr. Paul A. Williams of Rensselaer has been installed as president of the Indiana Academy of Family Physicians. Dr. Ross L. Egger of Daleville was installed as speaker, and Dr. Alvin J. Haley, Fort Wayne, was elected delegate to the American Academy of Family Physicians.

Dr. L. Ray Stewart of Evansville has been elected president of the medical staff at Deaconess Hospital. Dr. John R. Crist, Mount Vernon, was named president-elect, and Dr. Ronald L. Sowa, Evansville, was elected treasurer.

Appointment

Dr. Alfonso D. Holliday of Gary has been appointed adjunct assistant professor of nursing at Indiana University Northwest. He is co-director of the Family Nurse Practitioner Program, carried out jointly by the Medical Center of Gary and the university.

Drug Samples Collected

The St. Joseph County Medical Society Auxiliary recently completed its annual collection of drug samples from local physicians' offices for disbursement through World Relief, Inc. The organization distributes the drugs to hospitals and clinics in various underdeveloped countries.

Bibler Award Presented

Dr. Wilson L. Dalton of Shelbyville has received the Lester D. Bibler Award of the Indiana Academy of Family Physicians. The award, highest given by the organization, credited Dr. Dalton with "dedication and effective leadership in furthering the development of family medicine in the State of Indiana."

Honorary Fellowship Awarded

The American College of Physicians has awarded an Honorary Fellowship to Dr. John R. Vane who discovered the prostaglandin that prevents formation of blood clots leading to stroke and heart attack. Dr. Vane is the research and development director of The Wellcome Foundation, Ltd. of London, England. He found that the prostaglandin generated by the inner walls of blood vessels inhibits blood platelet aggregation. First named prostaglandin X, the hormone-like substance has been renamed prostacyclin.

I.U. Alumni Award

Dr. James H. Gosman, Indianapolis, was one of five Indiana University alumni who received the Distinguished Alumni award during commencement ceremonies in May. The awards are given each year to honor alumni for contributions to the various professional fields.

Diplomates Named

The following ISMA-member physicians have been named diplomates of the American Board of Family Practice:

- Dr. Alan J. Adler, Kokomo;
- Dr. William V. Croft, New Albany;
- Dr. Jerome E. Herrberg, Columbus;
- Dr. Friedrich Krause, Elkhart;
- Dr. Dennis F. Lawton, Muncie;
- Dr. Thomas A. Neathamer, Jeffersonville (ISMA Third District trustee);
- Dr. Lawrence F. Schneider, Columbus;
- Dr. Thomas J. Stolz, West Lafayette;
- Dr. R. Wyatt Weaver, Angola;
- Dr. E. T. (Ely) Banguis has been named a diplomate of the American Board of Abdominal Surgery. His wife, Dr. L. P. (Lou) Banguis, has been named a diplomate of the American Board of Family Practice. They practice at the Inlow Clinic, Shelbyville.

Dr. Richard L. Gilmore, Indianapolis, has been named a diplomate of the American Board of Neurological Surgery.

"Old Timers" Honor Founder

During its Old Timers game this spring, the University of Louisville Cardinals paid tribute to Dr. Hargis R. Bush, Cannelton physician for 50 years, for his role in founding the team 58 years ago. Dr. Bush played on the first Cardinal team in 1920, continuing until 1922.



Forget
Everything
you ever knew
about borrowing
Money

Introducing a new loan:
THE PROFESSIONAL

so unique that we have over \$4,000,000.00 in personal loans made to Physicians and Dentists.

- Unique Features...
- **PAY ANY AMOUNT ANY DAY OF THE MONTH.**
In good times, pay more. During slow periods, pay the minimum.
 - **WE MAKE HOUSE CALLS.**
A collect call is all that's necessary to begin processing your loan. We will come to your home, office or hospital to close your loan at your convenience.

This confidential loan is made for any good purpose . . . long term or short . . . \$10,000 to \$50,000. An interest-bearing loan, it can be repaid in varying amounts and on any day. You pay only for the time you use the money. Call today.

PROFESSIONAL LOAN DIVISION

Ask for Colin G. Haza
Assistant Vice President
110 East Washington Street
Indianapolis, Indiana 46204
Phone (317) 631-1311



NEWS NOTES

Blue Shield Cites Board Member

Dr. Frank H. Green of Rushville has received a plaque in recognition of 12 years service as a member of the Board of Directors, Blue Shield of Indiana. He was credited with various contributions to the Indiana health care system.

Bowen Center Dedicated

The Otis R. Bowen Center for Human Services, Inc. in Warsaw was dedicated in April. The center, named for Indiana's governor-physician, will provide mental health services to residents of Marshall, Kosciusko, Wabash, Huntington and Whitley Counties. It offers an inpatient service—18 psychiatric beds—and 24-hour emergency services.

Named Assistant Professor of Nursing

Dr. Alfonso D. Holliday of Gary has been appointed adjunct assistant professor of nursing at Indiana University Northwest (IUN). He is executive director of the Medical Center of Gary and co-director of the family nurse practitioner program at IUN. Dr. Holliday has been nominated for 1978 awards given by various "Who's Who" publications.

Health Group Cites 2 ISMA Members

Two ISMA members were among a group of 14 who received awards from the Indiana Public Health Association, Inc., in April. Dr. A. C. Offutt of Indianapolis, former state health commissioner, was named "Citizen of the Year." Dr. Ivan T. Lindgren of Lawrenceburg was cited for "physician leadership."

Pat on the Back

In the early 1960s the ISMA asked its membership for financial help in constructing its new headquarters at 3935 N. Meridian St., Indianapolis. At the time, the following member physicians provided loans for the Building Fund but, during the past year, converted those loans to tax-deductible contributions. We express our appreciation to these members for their generosity. Anyone wishing to donate their outstanding loans to the Building Fund—inflation continues to deal its expensive blow—will be issued an appropriate tax deductible business expense receipt.

Milton H. Anderson, M.D.
J. L. Arbogast, M.D.
Theodore D. Arlook, M.D.
Harry R. Baxter, M.D.
Walter M. Behn, Jr., M.D.
Frederic W. Bigler, M.D.
Robert N. Bills, M.D.
Paul Boren, M.D.
Otis R. Bowen, M.D.
Charles F. Bradley, M.D.
Welbon R. Britton, M.D.
Frances T. Brown, M.D.
Cecil Burket, M.D.
Robert Byrne, M.D.
J. Albert Carey, IV., M.D.
Herbert O. Chattin, M.D.
J. O. Conklin, M.D.
Vactor O. Connell, M.D.
Evan Constan, M.D.
Donald D. Du Sold, M.D.
F. J. Evans, M.D.
Donald L. Fields, M.D.
E. L. Fosbrink, M.D.
Jack M. Fox, M.D.
J. L. Frazier, M.D.
G. R. Gillespie, M.D.
E. M. Gillum, M.D.

Hubert T. Goodman, M.D.
John C. Gould, M.D.
Charles M. Gruber, Jr., M.D.
Peter E. Gutierrez, M.D.
Carl B. Harris, M.D.
Neil Harris, M.D.
I. C. Hernandez, M.D.
Howard E. Hill, M.D.
D. Stanley Houser, M.D.
Carroll Hyde, M.D.
George W. Irmischer, M.D.
Joe H. Jewett, M.D.
Joseph E. Kopcha, M.D.
John U. Lanman, M.D.
George T. Lukemeyer, M.D.
Ralph A. Lundeborg, M.D.
G. Lutz, M.D.
R. M. Madlang, M.D.
Charles L. Mahoney, M.D.
A. David McKinley, M.D.
Donald L. McKinney, M.D.
Frank E. Mead, M.D.
John R. Melin, M.D.
Samuel R. Mercer, M.D.
Harold E. Nelson, M.D.
C. K. Newsome, M.D.
Robert J. Nichols, M.D.

W. Robert Orr, M.D.
Julius W. Pastor, M.D.
Geraldine Peiffer, M.D.
Jack J. Pemberton, M.D.
F. F. Premuda, M.D.
Leo Roth, M.D.
Edward D. Plasterer, M.D.
Frank B. Ramsey, M.D.
Ruth F. Rasmussen, M.D.
A. C. Remich, M.D.
James Robertson, M.D.
Robert J. Rohn, M.D.
V. J. Santare, M.D.
Wayne Schrepferman, M.D.
John C. Shattuck, M.D.
E. M. Sirlin, M.D.
Robert E. Snodgrass, M.D.
Dan E. Talbott, M.D.
Ian S. Templeton, M.D.
H. B. Templin, M.D.
Maurice J. Thornton, M.D.
James N. Topolcus, M.D.
M. C. Topping, M.D.
Weldon Troyer, M.D.
Gert Voss, M.D.
Peter V. Westhaysen, M.D.

NEWS NOTES

Roche Public Issues Pamphlets

Hoffmann-LaRoche is preparing a series of pamphlets on subjects of interest to the general public which affect Roche and the pharmaceutical industry. The Journal has a small supply of the first three pamphlets and will furnish copies on request. Each of the three would be suitable for display on waiting room tables for distribution to and reading by patients. If, after reading the pamphlets, any physicians wish a waiting room supply Roche will be glad to furnish them in quantity. The first three subjects are: "Facts About Recombinant DNA Research", "Patents and Roche", and "Prices and Profits in the Pharmaceutical Industry."

Child Safety Publications

The Safety Now Company of P.O. Drawer 567, Jenkintown, Pa., 19046, specializes in child safety. They publish a book "A New Vaccine For Child Safety" that has had a very enthusiastic reception. In addition the company publishes a "Child Safety Catalog" that can be obtained by paying 25 cents for mailing expense. The catalog illustrates many ingenious devices for promotion of child safety, including the book described above.

Cited for Service to Israel

Dr. Werner L. Loewenstein, a Terre Haute general practitioner, was honored for outstanding service to Israel and to the community at a United Hebrew Congregation dinner marking Israel's 30th anniversary. Dr. Loewenstein, president of the Terre Haute Academy of Medicine, is a past president of the Vigo County Medical Society.

Heimlich Maneuver Taught

The life-saving Heimlich Maneuver is being taught in the South Bend area by the American Lung Association of North Central Indiana. Presentations include a short film, a "live" demonstration and a practice session for participants. The class, free of charge, takes only 30 minutes. The Heimlich Maneuver is a technique developed to clear the clogged breathing passage of a choking victim—about 4,000 Americans die of this problem each year.

Drug Addiction Newsletter Available

AMEP-O-GRAM is the newsletter of the Addictions Medical Education Program for southwestern Indiana. Dr. W. D. Snively, Jr. is the editor. The publication specializes in news of prevention, control and treatment for addictions to alcohol and other drugs. It is of special interest to physicians and is available free of charge to physicians interested in alcoholism. Write to Addictions Medical Education Program, Evansville Medical Center, University of Evansville, Box 329, Evansville 47702.

Medical Director Wanted

The Daniel Drake Memorial Hospital of Hamilton County, Ohio (near Cincinnati) is conducting a search for a full-time Medical Director. The specifications are board-certified internist or physiatrist with at least five years of clinical practice beyond residency who is licensed to practice medicine in Ohio and who is a fellow of a specialty college. Candidates are invited to write to C. B. Mueller, 151 W. Galbraith Road, Cincinnati 45216. Drake is a 500-bed, fully accredited, rehabilitation hospital.

Joins AAPA Board of Directors

Laurie Lipsig, a 1976 graduate of the Indiana University School of Medicine Physician Assistant Program, was elected recently to a two-year term on the Board of Directors of the American Academy of Physician Assistants. She now works as a physician assistant in surgery at Columbus Hospital in Chicago.

I.U. Med School Marks 75th Anniversary

With the beginning of Indiana University School of Medicine's 75th anniversary year in May, Dean Steven Beering announced establishment of the James O. Ritchey professorship of medicine. Dr. Ritchey, a 1917 graduate of the school and first recipient of the Ravdin Medal for high scholarship, is "one of the most distinguished Hoosier physicians of all time," Dr. Beering said. He was chairman of the department of medicine for 25 years and has headed the admissions committee since 1950. In his alumni report, Dr. Beering traced the medical school's progress from a department with six faculty members and 20 students in 1903 to a school that now graduates one of the largest medical classes in the nation and is complemented by outstanding research and treatment facilities.

Elmer Friman, 1930-1978



Elmer Friman, director of the Medical Educational Resources Program of Indiana University School of Medicine since 1971, died April 30 at the age of 48. Associate Dean Dr. George Lukemeyer said: "Mr. Friman brought a unique talent to the medical center and through his leadership forged an innovative statewide medical communications network to support continuing medical education for physicians in Indiana. He will be missed, but the contributions he has made to the health profession will stand as a memorial to his dedication."

NEWS NOTES

Paper Earns Research Award

Dr. William R. Keye of Bluffton, a specialist in obstetrics/gynecology, reproductive endocrinology and infertility, has received the Purdue Frederick Award for excellence in medical research. The award was presented by the American College of Obstetricians and Gynecologists for Dr. Keye's paper, "Prolactin Secreting Adenomas in Women with Amenorrhea and Galactorrhea." It deals with the diagnosis and treatment of pituitary tumors that interfere with normal menstrual periods and fertility.

Health Service Honors

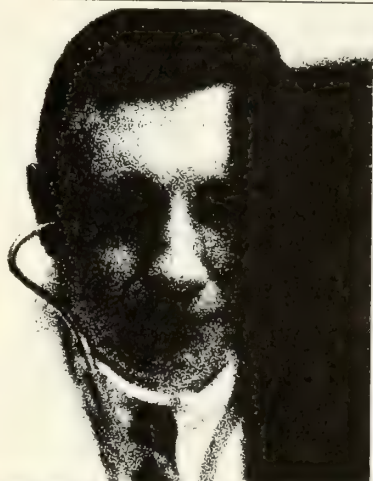
Two Bloomington physicians were among those credited with service to the community during the recent annual Health Services Recognition Day breakfast in Bloomington. They are Dr. Thomas O. Middleton, a pediatrician, and Dr. Lawrence D. Rink, an internist. Dr. Middleton received the Humanitarian Award for "outstanding health services by a physician to the community, exemplifying the highest in medical ideals, ethics and objectives." Dr. Rink received the Quality of Life Award, presented to the individual "most responsible for initiating a new service for the community . . . which results in raising the quality of life for people." He was instrumental in starting a cardiac rehabilitation program, sponsored jointly by Bloomington Hospital and the Monroe County YMCA.

New Hypertension Film

A new 24-minute film, designed to inform the public about the risks and prevalence of high blood pressure, communicates to people of various languages by the use of animation, mime and music. Its title is "High Blood Pressure—If Only It Hurt a Little." It was produced for the American Heart Association and the International Society and Federation of Cardiology with grant support from Merck Sharp & Dohme. It is available on free loan from West Glen Films, 565 Fifth Ave., New York City.

Kiwanis Honor Dr. Halleck

Dr. Harold J. Halleck of Winamac has been presented the Kiwanis International Legion of Honor 50-Year Membership Award. Dr. Halleck, a retired general practitioner, also received the Past President 50-Year Lapel Pin. He had served as the Winamac Kiwanis' president in 1940. He was credited with 50 years of membership and 18 years of perfect attendance.

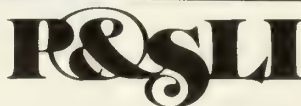


MALPRACTICE INSURANCE AVAILABLE

Owned by
PHYSICIANS

Operated by
PHYSICIANS

For the protection of
PHYSICIANS



Physicians & Surgeons Liability Insurance Co., Inc.
800 MacArthur Boulevard / Munster, Indiana 46321
219 836-2288

COMMERCIAL ANNOUNCEMENTS

Commercial announcements are carried in The Journal as a special service to ISMA members. Only advertisements considered by publisher to be of advantage to members will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

20¢ for each word

\$4.00 minimum

Send cash with order. Average count: seven words to the line.

Address: The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

DEADLINE: Fifth day of month PRECEDING month of issue.

EMERGENCY MEDICINE—DIRECTORSHIP OPEN—to join established three-man group. Guaranteed salary with benefits; profit sharing, major medical and disability insurances, medical allowance, two weeks paid vacation, two weeks for CME, and a partnership after 12 months. Community located on Cincinnati's I-175. Call or write Dr. G. T. Bowen at Dearborn County Hospital, Lawrenceburg, Ind. 47025. (812) 537-1010.

OPPORTUNITIES FOR PHYSICIANS—There are several excellent openings among the Indiana State Hospitals at various locations throughout the State for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Candidates must be licensable in Indiana. Please reply with a copy of the c.v. to: FARABEE & ASSOCIATES, INC., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

EXCELLENT OPPORTUNITY—Physician—for Disability Determination Division, Indiana Rehabilitation Services. No insurance requirements, no patient load, low-pressure atmosphere, excellent fringe benefits. Contact the Personnel Officer, 1-317-633-6828, or write above agency at Room 1010 Illinois Bldg., 17 W. Market St., Indianapolis 46204.

TAX ADVANTAGED LEASING—Fixtures, equipment, machinery, furniture and automobiles. Accelerated depreciation with investment tax credits. (317) 291-9342.

PHYSICIAN'S OFFICE AVAILABLE—Has been physician's office for last 8 years. Eastside, 5 minutes from St. Francis and Community Hospitals. All utilities except phone. American alarm, private parking, large waiting room. (317) 357-7657 or 357-2403.

INTERNIST AND FAMILY PHYSICIAN: Established need for both an internist and a family physician to join 7-man group in beautiful northwest Iowa. New clinic building of 10,000 square feet is located next door to 88-bed county hospital. Unusually progressive community of 10,000 offers 3,000-acre lake, 85 acres of parks and recreation, local liberal arts college, and many family interest features. Generous salary with incentive, malpractice insurance, liberal vacation and seminar time, partnership in one year. Contact D. A. Pritchard, administrator, Buena Vista Clinic, 620 N. Western Drive, Storm Lake, Iowa 50588.

INTERNIST WANTED: Recent graduate of American university to associate in practice with busy board-certified internist. L. Lenyo, M.D., 2100 N. Center, Terre Haute, Ind. 47804.

COLORADO MOUNTAIN VALLEY FOR SALE. Equidistant from Breckenridge, Denver, Colorado Springs. Abuts on Pike National Forest. Perfect, very private retreat. Contact Hay Creek Ranch, P.O. Box 1214, Breckenridge, Colo. 80424.

PHYSICIANS' ASSISTANT with National Certification and Family Practice and Surgery experience is interested in a Family Practice, a Surgery, or an Emergency Room opportunity. Prefers group practice, but would consider a private practice. Contact Steven M. Trimble, P.A.-C., 353 State St., Wabash, Ind. 46992.

CAPE COD: FALMOUTH. Sale. Luxurious townhouse condominium. Excellent investment. Two bedrooms, 1½ baths, wood-burning fireplace for chilly evenings. Very private. Only 41 units on 25 heavily wooded acres. Swimming pool, tennis court. Near ocean beaches, golf, shopping. Rent and/or use. Harold Bach, R.E. (617) 540-0707.

FOR SALE: Modern office, 1,056 square feet, on choice business lot in town. Established practice of 48 years. Will sell outright or on short term contract. Private parking, four treatment rooms, waiting room, reception, drug, storage and bathroom. Location south central Indiana, State Road 37, 40 miles south of Bloomington, 55 miles northwest of Louisville. Office phone (812) 865-3350, residence (812) 865-3351.

FOR SALE: X-ray machine and all needed accessories. Good condition. Also miscellaneous office equipment, exam tables, etc. Contact Dr. Michael Derry at (219) 842-3327.

FAMILY PRACTICE: Board certified/eligible family practitioner needed by large multi-specialty group in northwest Ohio. Perfect opportunity for right individual to establish satellite practice in conjunction with a well established large group practice. Top salary and fringes being offered as a member of the group, along with other corporate benefits. Please forward curriculum vitae, salary requirements to Box J, The Journal.

ORTHOPEDIC SURGEON: Board certified/eligible orthopedic surgeon needed by well established, 42-physician multi-specialty group in northwest Ohio. Major regional medical center with large referral base. Staff includes four Rheumatologists. Top salary, excellent fringe benefit program along with all corporate benefits. Please forward current curriculum vitae, salary requirements to Box J, The Journal.

PHYSICIAN with empathy toward college-age population to practice general medicine in 38-bed accredited hospital with large outpatient clinic. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., director, Purdue University Student Hospital, West Lafayette, Ind. 47907. (317) 749-2441.

PHYSICIANS' DIRECTORY

INTERNAL MEDICINE

Offices for the doctors listed below are located at 3130 N. Meridian St., Indianapolis 46208; telephone numbers are listed in the new telephone directory. The switchboard number is 317-927-1221.

MERIDIAN MEDICAL GROUP

CARDIOLOGY

Richard M. Nay, M.D.
Warren E. Coggeshall, M.D.
Richard R. Schumacher, M.D.
William C. Elliott, M.D.

HEMATOLOGY—ONCOLOGY

Laurence H. Bates, M.D.
William M. Dugan, Jr., M.D.
James E. Schroeder, M.D.
Frank A. Workman, M.D.
Deborah S. Provisor, M.D.
Pediatrics

GASTROENTEROLOGY

Robert D. Pickett, M.D.
B. T. Maxam, M.D.
Lee G. Jordan, M.D.

INTERNAL MEDICINE

Hunter A. Soper, M.D.
Douglas H. White, Jr., M.D.
Michael B. DuBois, M.D.

Nephrology

Michael P. Bubbs, M.D.
Robert L. Iverson, M.D.
Critical Care
Michael Zeckel, M.D.

METABOLISM AND ENDOCRINOLOGY

William M. Holland, M.D.

NEUROSURGERY

By Appointment

Phone 925-4255

C. BASIL FAUSSET, M.D.

Neurological Surgery

1815 North Capitol Avenue

Indianapolis 46202

By appointment only

Phone 317-353-6800

BIO MEDICAL LABORATORY

5506 East 16th St., Suite 24

Indianapolis 46218

Bio-Feedback Training for Migraine and Tension Headache

KARL L. MANDERS, M.D.

JOHN S. MARKS, JR., M.D.

MALCOLM S. SNELL, M.D.

PLASTIC SURGERY

NEPHROLOGY & INTERNAL MEDICINE, INC.

Daniel J. Ahearn, M.D.

Thomas Wm. Alley, M.D., FACP

George W. Applegate, M.D.

Charles B. Carter, M.D.

William H. Dick, M.D., FACP

Theodore F. Hegeman, M.D.

Douglas F. Johnstone, M.D.

LeRoy H. King, Jr., M.D., FACP

2020 W. 86th St., #307, Indianapolis 46260 Ph: 317-844-9911

1633 N. Capitol, #722, Indianapolis 46202 Ph: 317-925-6034

Answering Service 926-3466

CLINICAL NEPHROLOGY, RENAL TRANSPLANTATION, HEMODIALYSIS, PERITONEAL DIALYSIS, HYPERTENSION, FLUID AND ELECTROLYTE IMBALANCE, CRITICAL CARE.

PLASTIC & HAND SURGERY CLINIC, INC.

1944 N. Capitol Ave.

Indianapolis 46202

"An office surgery facility"

Haroon M. Qazi, M.D.

Diplomate, American Board of Plastic Surgery

Phone: 317-923-4822

317-926-3466

HAND SURGERY

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

By appointment

Phone 317-783-1319

VIDYASAGAR S. TUMULURI, M.D., F.A.C.S., INC.

Diplomate American Board of Surgery

Acute & Reconstructive Hand Surgery

General Surgery

3530 S. Keystone, Suite 305

Indianapolis 46227

PHYSICIANS' DIRECTORY

PSYCHIATRY

JOHN H. GREIST, M.D.

Diplomate, Board of Neurology and Psychiatry

Specializing in Psychiatry

3231 North Meridian Street

Indianapolis 46208

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALLERGY

INDIANA ASTHMA & ALLERGY ASSOCIATES

Specializing in Chronic Severe Asthma
and

Adult and Pediatric Allergic Disorders

D. Duane Houser, M.D., Inc.

(317) 923-7650

and

Douglas J. Horton, M.D.

(317) 923-6990

1815 N. Capitol Avenue
Indianapolis, Indiana 46202

Diplomates, American Board
of Allergy & Immunology

Answering Service 926-3466



LET US GIVE YOU A LIFT...

Yellow Medi-Car service is now available to all persons confined to a wheel chair. If a person is ill, handicapped, physically limited or aged and must use a wheel chair, the new non-scheduled van service of Yellow Medi-Car is available with prior notice or by 24 hour reservation. These new modern vans with a level, hydraulic lift can be used to transport wheel chair passengers to work, shopping, visit relatives and friends, obtain medical treatment or medicine, and to attend church and recreational events.

SERVICE AREAS:

Indianapolis and Marion,
Boone, Madison, Hamilton,
Hendricks, Johnson, Morgan,
Hancock and Shelby Counties.



Yellow Medi-Car

FOR FURTHER INFORMATION

CALL 637-5421

**WE MAKE
HOUSE CALLS!!**

Where people come first

OBITUARIES

Stanley W. Burwell, M.D.

Dr. Burwell, 62, a Muncie surgeon, died May 8 at Ball Memorial Hospital in Muncie.

He was a 1942 graduate of the College of Physicians and Surgeons, New York City. A former fellow in surgery at Lahey Clinic, Boston, Dr. Burwell practiced general surgery at Lynchburg (Va.) General Hospital before moving to Muncie in 1952.

Dr. Burwell was a former president of the Delaware-Blackford County Medical Society and had served on ISMA's Commission on Public Health and Preventive Medicine from 1969-72. Listed in Who's Who in the Midwest for many years, he was a fellow of the American College of Surgeons and a diplomate of the American Board of Surgery.

Howard T. Hammel, M.D.

Dr. Hammel, 56, a Bedford physician, was killed in an automobile accident near his home at Springville May 18.

He was a 1945 graduate of the Indiana University School of Medicine and had been a member of the American Academy of Family Physicians.

Milton H. Omstead, M.D.

Dr. Omstead, 68, a Petersburg physician for 35 years, died April 3 at St. Mary's Medical Center, Evansville.

He was a 1936 graduate of the Indiana University School of Medicine.

A World War II veteran, Dr. Omstead had long been active in the Indiana State Medical Association and was a former president of the Pike County Medical Society.

James A. Waggener



Mr. Waggener, executive secretary emeritus of the Indiana State Medical Association, died May 28 at his home. He was 67.

Mr. Waggener had completed 27 years with ISMA, 25 as executive secretary. Until his death he remained active in the medical community, serving as secretary of the

National Conference of Presidents and Officers of State Medical Associations. He had held that position since 1954.

He had served on the Public Relations Advisory Committee of the American Medical Association for several years, and was elected an honorary member of ISMA in 1969.

Cecil S. Wright, M.D.

Dr. Wright, 83, an Anderson physician since 1937, died May 22 at St. John's Hospital in that city.

Born in Ontario, Canada, Dr. Wright was a 1923 graduate of Northwestern University Medical School, Chicago. He had practiced in Indianapolis for six years before moving to Anderson where he served as a radiologist at St. John's Hospital until he retired in 1958.

Dr. Wright, a senior member of the Indiana State Medical Association, was a past president of the Madison County Medical Association, a member of the Indiana Medical Association and a member of the American College of Radiology.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of **The Journal**. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

1978 Annual Meeting—Oct. 22-25—Clarksville

OFFICERS FOR 1977-78

President—Eli Goodman, 807 High St., Charlestown 47111

President-Elect—James A. Harshman, M.D., St. Joseph Hospital, Kokomo 46901

Treasurer—Arvine G. Popplewell, 3530 S. Keystone, Indianapolis 46227

Assistant Treasurer—Joseph F. Ferrara, 111 S. Water St., Franklin 46131

Executive Committee—John W. Beeler, 1815 N. Capitol Ave., Indianapolis 46202, Chairman; Richard G. Ingram, 206 S. Main St., Montpelier 47359; Joe Dukes, Dugger 47848, Members

Speaker of the House—Lloyd L. Hill, 302 N. Duke St., Peru 46970

Vice Speaker—Lawrence E. Allen, 2009 Brown St., Anderson 46016

Executive Director—Mr. Donald F. Foy

TRUSTEES

District	Term Expires
1—John A. Bizal, Evansville	Oct. 1980
2—Paul W. Holtzman, Bloomington	Oct. 1978
3—Thomas A. Neathamer, Jeffersonville	Oct. 1979
4—Howard C. Jackson, Madison	Oct. 1980
5—Cleon M. Schauwecker, Greencastle	Oct. 1978
6—Davis W. Ellis, Rushville	Oct. 1979
7—Donald C. McCallum, Indianapolis	Oct. 1980
7—John G. Pantzer, Indianapolis	Oct. 1978
8—Jack M. Walker, Muncie	Oct. 1978
9—John A. Knot, Lafayette	Oct. 1979
10—Martin J. O'Neill, Valparaiso	Oct. 1980
11—Herbert C. Khalouf, Marion	Oct. 1978
12—Alvin J. Haley, Fort Wayne	Oct. 1979
13—Donald S. Chamberlain, South Bend	Oct. 1980

ALTERNATES

District	Term Expires
1—E. DeVerre Gourieux, Evansville	Oct. 1979
2—Edgar R. Cantwell, Vincennes	Oct. 1980
3—Richard G. Huber, Bedford	Oct. 1980
4—Mark M. Bevers, Seymour	Oct. 1979
5—William G. Bannon, Terre Haute	Oct. 1979
6—Dan W. Hibner, Richmond	Oct. 1981
7—I. E. Michael, Indianapolis	Oct. 1979
7—Gerald J. Kurlander, Indianapolis	Oct. 1979
8—Ted S. Doels, Middletown	Oct. 1979
9—Max N. Hoffman, Covington	Oct. 1980
10—Leonard W. Neal, Munster	Oct. 1978
11—Fred C. Poehler, La Fontaine	Oct. 1980
12—Franklin A. Bryan, Fort Wayne	Oct. 1980
13—John W. Luce, Michigan City	Oct. 1979

SECTION OFFICERS 1977-1978

Section on Surgery

Chairman—Jay L. Grosfeld, Indianapolis

Secretary—James A. Madura, Indianapolis

Section on Internal Medicine

President—Douglas H. White, Indianapolis

Secy-Treasurer—William Bastnagel, Indianapolis

Section on Family Practice

Chairman—Harvey Himelstein, Indianapolis

Secretary—Bernard J. Emkes, Indianapolis

Section on Obstetrics and Gynecology

Chairman—Charles R. Thomas, Indianapolis

Secretary—Hans E. Geisler, Indianapolis

Section on Ophthalmology and Otolaryngology

Chairman—John Bizal, Evansville

Secretary—Daniel R. Evans, Valparaiso

Section on Anesthesiology

Chairman—Normand Townley, Indianapolis

Secretary—Wendell Edwards, Indianapolis

Section on Public Health and Preventive Medicine

Chairman—Ivan T. Lindgren, Aurora

Secretary—David J. Edwards, Indianapolis

Section on Radiology

Chairman—Edwin F. Koch, Jr., Muncie

Secretary—Richard Fox, Fort Wayne

Section on Nervous and Mental Diseases

Chairman—Philip M. Morton, Indianapolis

Secretary—Jeffrey J. Kellams, Indianapolis

Section on Pathology and Forensic Medicine

Chairman—Robert Reed, Columbus

Secretary—David E. Smith, Indianapolis

Section on Pediatrics

Chairman—Robert Hannemann, Lafayette

Secretary—William C. Ashman, Fort Wayne

Section on Directors of Medical Education

Chairman—W. Thomas Spain, Evansville

Secretary—Robert Robinson, Indianapolis

Section on Cutaneous Medicine

Chairman—Edward Probst, Columbus

Secretary—Patrick Logan, Indianapolis

Section on Allergy

Chairman—Paul D. Isenberg, Indianapolis

Secretary—Beauford Spencer, Bloomington

Section on Urology

Chairman—Russell L. Judd, Indianapolis

Secretary—David Schlueter, Fort Wayne

Section on Orthopedic Surgery

Chairman—Robert F. Kimbrough, Fort Wayne

Secretary—Morris S. Friedman, South Bend

Section on Emergency Medicine

Chairman—David Gettle, Indianapolis

Secretary—Carolyn Cunningham, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1978:

Delegates: James A. Harshman, Kokomo; Malcolm O. Scamhorn, Pittsboro; Ross L. Egger, Daleville.

Alternates: George T. Lukemeyer, Indianapolis; Everett E. Bickers, Floyds Knobs; Gilbert M. Wilhelmus, Evansville.

Terms expire December 31, 1979:

Delegates: Patrick J. V. Corcoran, Evansville; Peter R. Petrich, Altica.

Alternates: Thomas C. Tyrrell, Hammond; Marvin E. Priddy, Fort Wayne.

DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place, Date of Meeting
1.	Forrest Radcliff, Evansville	William R. Wells, Princeton	May 17, 1979, Evansville
2.	Joe Dukes, Dugger	James P. Beck, Washington	1979, Sullivan
3.	Marvin McClain, Scottsburg	Charles X. McCalla, Paoli	Oct. 7-8, Scottsburg
4.	Brockton L. Weisenberger, Columbus	John I. Cooper, Madison	1979, Columbus
5.	J. B. Kho, Terre Haute	Clyde Jett, Seelyville	May 9, 1979, Terre Haute
6.	Hal R. Rhynearson, Fortville	Douglas Morrell, Rushville	
7.	Stephen L. Hardin, Martinsville	M. O. Scamahorn, Pittsboro	May 23, 1979
8.	Lowell W. Painter, Winchester	Howard Koch, Winchester	June 13, 1979
9.	Adrian Lanning, Noblesville	John A. Knot, Lafayette	June 14, 1979
10.	Lee H. Trachtenberg, Munster	Barron M. F. Palmer, Hammond	
11.	Amando L. Baluyot, Peru	Fred Poehler, La Fontaine	Sept. 20, Peru
12.	Thomas A. Felger, Fort Wayne	R. Wyatt Weaver, Angola	Sept. 7, Fort Wayne
13.	David L. Spalding, Mishawaka	Michael G. Quinn, South Bend	Sept. 13, South Bend



"Efficiency is the key to your practice"

Graduates of P. C. I. are thoroughly trained in the most up-to-date methods as Medical Assistants (AMA accredited) and Medical Receptionists.

PROFESSIONAL CAREERS INSTITUTE

6321 La Pas Trail, Indianapolis, IN 46268
Telephone: (317) 299-6001

Are You Moving?

If so, please send change of address to Membership Dept., ISMA, 3935 N. Meridian St., Indianapolis, IN 46208, at least six weeks before you move.

Name _____

Address _____

City _____

State _____

Zip _____

County _____

IMPORTANT — Attach mailing label from your last Journal here.

ADVERTISERS IN THIS ISSUE

July 1978

Vol. 71

No. 7

American Medical Association	670
Blue Cross-Blue Shield	641
Bristol Laboratories	664, 665
Brown Pharmaceutical Co., Inc.	649
Burroughs Wellcome Co.	658
Giganti, Inc.	683
Immke Circle Leasing, Inc.	672
Indiana Medical Bureau	712
Lilly, Eli and Company, Inc.	667
McClain Car Leasing, Inc.	663
Mead Johnson Laboratories	703, 704
Medical Protective Company	691
Morris Plan	715
P&SLI	717
Pennwalt Corp.	668, 669
Professional Careers Institute	724
Purepac Pharmaceutical Co.	711
Roche Laboratories	Covers, 639, 656
Rockwood Insurance Company	653
Smith, Kline & French	655, 676, 677
The Pointe	645
The Upjohn Company	643
U.S. Air Force	647
Warren-Teed Laboratories, Inc.	657
Yellow Medi-Car	721

In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

August 1978 • Vol. 71 • No. 8

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION



LIBRARY
U.C. SAN FRANCISCO

AUG 16 1978

The University of California, San Francisco
U. of Calif., San Francisco, CA 94143
SAN FRANCISCO, CA 94143

THE MESSAGE OF TENSION

HEADACHES

SWEATS

TENSE, TAUT MUSCLES

HYPERVENTILATION

TACHYCARDIA

PALPITATIONS

BURNING IN STOMACH

FULLNESS

FREQUENCY

to relieve psychic tension
and its functional symptoms

VALIUM[®]
(diazepam)[®]

2-mg, 5-mg, 10-mg scored tablets

VALIUM[®] (diazepam)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjuvantly in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjuvantly in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia.

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

Dr. Charles Hazelrigg, a dentist and pharmacist, is historian of Central State Hospital, Indianapolis. He recently discovered this series of photographs of the old Pathology Building, now being used as the Indiana Medical History Museum.

The photos appear to have been taken in about 1900. Although the light fixtures shown are electric, the build-

ing was originally gas illuminated. When it was wired for electricity, the original gas pipes were used for conduit.

The light fixtures, as well as the linoleum floors shown, were replaced during the Depression years. Except for these two changes, the rooms are essentially unchanged today.



THE HISTOLOGY LABORATORY

Has remained essentially unchanged for 75 years



THE LIBRARY

Subjects cannot be identified



THE RECEPTION ROOM

Furniture is still in the building
Some pieces have been restored, others will be



THE AMPHITHEATER

Was used for anatomy and pathology demonstration
Was also used for didactic purposes

WHAT'S NEW?

Norwich-Eaton Pharmaceuticals is introducing an optimal single-tablet medicament for treatment of post-operative and postpartum urinary retention. Duvoid® (bethanechol chloride) selectively increases bladder muscle tone and usually produces a contraction strong enough to empty the bladder.

Thomas Built Buses has announced a specially designed and fabricated bus that includes features such as wheel chair and other special seating accommodations. The bus has an Electro Hydraulic Lift as standard equipment. Any combination of interior arrangements for wheelchairs and regular seating can be specified. Built-in wheelchair locks secure chairs while the bus is moving.

Norwich-Eaton is introducing a product for the treatment of atopic dermatitis and eczema. Alphaderm® contains 1% hydrocortisone in a powder-in-cream delivery system. The base is described as a vanishing ointment. Alphaderm is widely used in the United Kingdom because of effectiveness plus safety with greater economy than the fluorinated steroids.

Roche stresses the early therapeutic benefits from a drug combination that helps depressed patients stay on treatment. Limbitrol®, a combination of chlordiazepoxide and amitriptyline, has been demonstrated by clinical research to relieve depression more quickly than either of its two ingredients and to also have a drop-out rate one-third less than that occurring with an anti-depressant drug alone.

Proctor & Gamble has announced the first oral therapeutic agent for symptomatic Paget's disease. Didronel® (etidronate disodium) is the disodium salt of a diphosphonic acid. It leads to significant reduction in the rapid bone turnover in pagetic bone and slows normal remodeling. Didronel is given once daily with a usual course of therapy of six months.

Parke-Davis is introducing Unit-Use Underpads for bed patients. Unit-Use Underpads keep the patient more comfortable, and bedclothes drier, through the use of a highly absorbent cellulose fluff-filler. They come with either polyethylene or polypropylene backings and are packed in units of 10.

Litton has a new six-page brochure covering the Litton Oxymonitor™ system for continuous, non-invasive monitoring of blood oxygen levels. Copies are obtainable by addressing Litton at 777 Nicholas Blvd., Elk Grove, Ill. 60007.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

Narco/Air-Shields has an improved collection system for suction-drainage of gastro-intestinal tubes and wounds. It consists of a disposable collection system and a reliable, flexible, low-volume drainage pump. Suction is automatically stopped for 10 seconds once per minute. It is lightweight, highly mobile, occupies a minimum of space and is highly efficient.

Judge Daniel J. Davidson, a Food and Drug Administrative Law judge, has ruled that Benylin Cough Syrup is safe and effective for over-the-counter marketing. The product was categorized as "by prescription only" on orders by the FDA in April. The judge's decision is subject to review by the FDA commissioner before Benylin can be returned to non-prescription status.

IN BOOKS . . .

Heath and Company has announced the release by Lexington Books of "Sexual Assault of Children and Adolescents." It is written as a guide to providing comprehensive human care for those people whose work brings them into contact with either the victim or the offender in such cases. The authors are Nicholas Groth, clinical psychologist, and Mary Keefe, former commanding officer for the Sex Crimes Analysis Unit of the New York City Police Department. 272 pages—\$20.

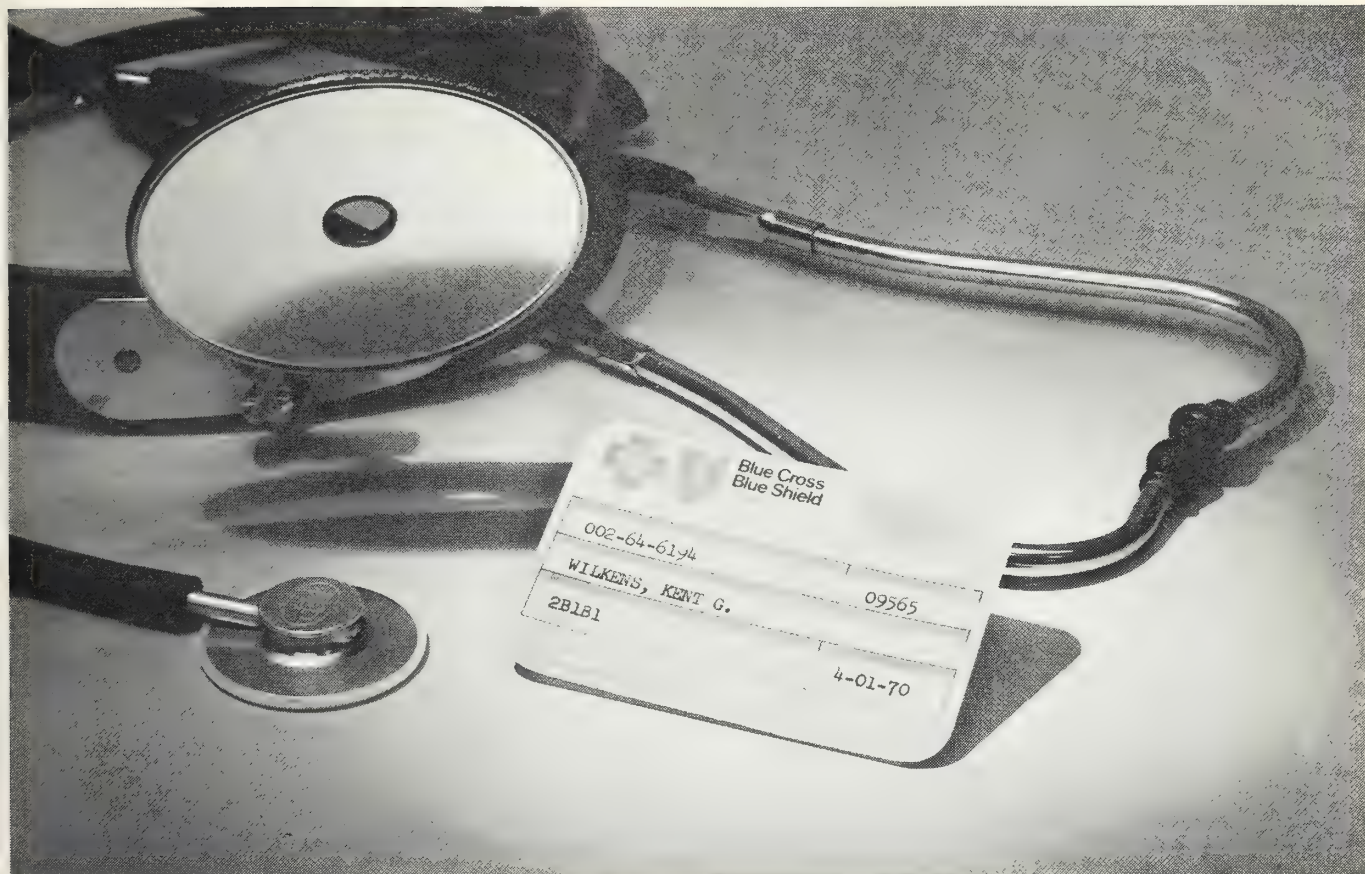
Van Nostrand Reinhold has released "Integration and Coordination of Metabolic Processes: A Systems Approach to Endocrinology" by J. H. U. Brown, Ph.D. It is described as the first truly comprehensive examination of the interrelationships and coordination that occur between endocrine systems. A separate section is devoted to each organ system. 253 pages plus index—67 illustrations—\$15.95.

There is a new health book for the traveler—what to do if you get sick in a foreign country. The title is "Bon Voyage And Salud." It is written by Sydney Kofman, M.D., and tells how to prepare for, prevent and treat jet lag, mountain sickness, disturbances of the stomach and many more. Includes a five-language dictionary of commonly used medical phrases. 256 pages—paperback \$4.95. Quantity prices for groups.

Anchor Press has released "The Malpractitioners" by John Guinther, an investigative reporter for **Philadelphia Magazine**. The book examines the malpractice crisis, including the roles of doctors, hospitals, patients, lawyers, judges, juries, politicians, drug manufacturers and medical suppliers. Guinther also covers the relationship between escalating premiums and the stock market crisis. 360 pages—\$10.

Contemporary Publishing has a new book by Howard F. Corbus, M.D. and L. L. Swanson. Called "Adopting the Problem Oriented Medical Record in Nursing Homes," it is illustrated and sells for \$5.95 in perfect binding.

Take advantage of a great association!



Get these special benefits – available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage – and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association – entitling you to special group rates for these benefits:

- One full year in-hospital care
- 100% semi-private room and hospital extras
- Allowances for surgery, anesthesia, obstetrics, medical visits, diagnostic and radiation therapy
- \$250,000 Major Medical Benefits

That's not all. You also benefit from the immediate recognition and automatic acceptance of the Blue Cross and Blue Shield membership card. The special rates available through the Indiana State Medical Association membership make this coverage your best investment in personal protection. You can get it – now.

Call or write: Mrs. Kathryn Eads,
Professional Accounts, Blue Cross and Blue
Shield of Indiana, 120 W. Market Street,
Indianapolis, Indiana 46204. Telephone: (317)
263-4925.

120 West Market St.
Indianapolis, Ind. 46204

® Reg. Mark Blue Cross Assn
* Reg. Serv. Mark. Nat'l Assn
of Blue Shield Plans



**Blue Cross
Blue Shield**
of Indiana

Contents

SCIENTIFIC ARTICLES

- 756 Hemorrhagic Diatheses—A. S. Ahmadzai, M.D. (*Sandoz Prize Article—Seventh in the Continuing Medical Education series*)
- 763 Pulmonary Tuberculosis—Richard Ziegler, M.D. (*Eighth Continuing Medical Education article*)
- 771 A Study in Longevity—J. Franklin Swaim, M.D.
- 774 Poison Ivy (Rhus) Dermatitis—Jere D. Guin, M.D.
- 776 Survival Rates of Major Abdominal Vascular Injury—Peter B. Yaw, M.D.
- 780 Radiation-Associated Thyroid Cancer—Corbin P. Roubush, M.D.

EDITORIALS

- 730 The Quality of Drugs
- 730 Second Opinion and Unnecessary Surgery
- 731 Editorial Notes

SPECIAL FEATURES

- 731 Reflections—Morris S. Friedman, M.D.
- 732 National Cancer Program—Arthur C. Upton, M.D.
- 734 Commentary: A Good Death—Newsweek, Inc.
- 752 'Oh, Doc's a Good Guy': John A. Davis, M.D.

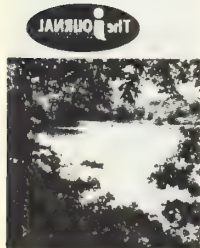
DEPARTMENTS, MISCELLANEOUS

- 725 Museum Notes—Charles A. Bonsett, M.D.
- 726 What's New?
- 738 Month in Washington
- 742 Tax Tips—Lawrence A. Jegen III, J.D.
- 746 There's a Word for It—Richard J. Noveroske, M.D.
- 748 Auxiliary Report—Mrs. Abner P. Bennett, president-elect
- 751 From The Journal 50 Years Ago
- 754 Notes from Down Under—Douglas F. Johnstone, M.D.
- 786 News Notes
- 790 Book Reviews
- 794 Future File
- 798 Obituaries
- 799 County Medical Society Directory

ABOUT THE COVER

Boating and fishing for bass, crappies and bluegills on one of two lakes at Shakamak State Park is a great way to relax. The park, located on Indiana 48 and 159 near Jasonville, Ind., lies in Clay, Green and Sullivan counties. Shakamak offers a thousand acres of scenic woodland and a variety of recreational facilities.

PHOTO COURTESY OF INDIANA DEPARTMENT OF NATURAL RESOURCES



EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue.

Representative for national advertising is the State Medical Journal Advertising Bureau, 711 South Blvd., Oak Park, Ill. 60302.

Annual subscription rates: ISMA members, \$8, included in annual membership dues; ISMA senior members, \$10; Libraries, \$12; all others, \$14. Additional postage: Canada and PUAS countries, \$2; Foreign, \$3. Subscriptions are renewable in July and January.

Entered as second class matter January 25, 1933, at the Post-office at Indianapolis, Indiana.

Copyright 1978 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian St., Indianapolis 46208. All material subject to this copyright may be copied for the noncommercial purpose of scientific or educational advancement.

Second class postage paid at Indianapolis, Indiana, and at additional mailing office.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

Our International Standard Serial Number is ISSN 0019-6770.

Indexed in Index Medicus and Hospital Literature Index.

contains no aspirin

tablets
Darvocet-N[®] 100 (IV)

100 mg. Darvon-N[®] (propoxyphene napsylate)
650 mg. acetaminophen



700565

*Additional information available
to the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46206*

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

EDITORIALS

The Quality of Drugs

Pharmaceutical manufacturing firms with large and intensive research departments have, naturally, been the discoverers of the new drug entities. The newly discovered drugs are customarily manufactured and distributed under brand names. At the end of the patent protection period these drugs are eligible for, and in many instances, are manufactured by other companies under generic designations. The drug firms that produce pharmaceuticals after patent expiration may also have active research programs or they may not.

The American pharmaceutical industry is famous for discovery and introduction of new pharmaceutical products. While the origination of new remedies is justification enough for the expenditures which the discovery process involves, it is not the only benefit. Drugs manufactured by research intensive companies have a most exemplary record of quality and reliability when they are compared with the products of manufacturers with either no research activities or only

minor research at best.

An analysis by Eli Lilly and Company shows that products of firms not spending great amounts on research have at least

- Seven times more FDA recalls,

- 43 times more FDA-initiated court actions against them, and

- One-and-one-half times more FDA Drug Product Problem Reports

than those of the 23 firms in the research-intensive category.

Despite the fact that the record of drug recalls and other drug monitoring activities is the record of the functions performed by the FDA in the interest of drug quality, various and sundry of the spokesmen for the FDA have, on numerous occasions and for a period of many years, announced publicly that there is no evidence that would indicate any variation in quality of drug products when produced by various makers.

Either the efficacy of the FDA drug testing is at fault or its spokesmen are misleading the public.

Second Opinion and Unnecessary Surgery

Ralph S. Emerson, M.D., under the above quoted title, discusses second opinions on the editorial page of the May 1978 issue of the New York State Journal of Medicine.

Blue Cross and Blue Shield of Greater New York offered to pay for a second opinion on the question of surgical operations to all its 4.5 million subscribers over a period of 18 months.

During the 18 months approximately 600,000 operations were performed for the group of 4.5 million. Only 1,500 persons requested a free second opinion, and of this number only 27% encountered a contrary opinion.

Dr. Emerson states that the 99.75% who did not

ask for second opinion must have had confidence in their physician, or had symptoms sufficient to convince them that the advice was correct, or agreed to the operation to avoid offending the physician. The last supposition is discarded by Dr. Emerson (he doesn't know of any New Yorkers so bashful as not to speak up in such a circumstance.)

Another interesting and comforting statistic is that, in the group of 1,500, there were only 4% who did not have positive physical findings. This produces an accuracy rate of 96% which, Dr. Emerson wishes, could be equalled by our legal colleagues, economists, legislators, business leaders and politicians.

Second opinions and even third opinions should not

CONTINUED ON NEXT PAGE

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 3935 N. Meridian Street, Indianapolis 46208.

Consulting Editors: A. W. Cavins, M.D., R.R. 25, Box 172, Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1, Box 202, Gaston 47342; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne 46802; I. W. Wilkens, M.D., 4820 E. Pleasant Run Pkwy., N. Dr., Indianapolis 46201; W. D. Snively, Jr., M.D., R.R. 1, Box 227, Evansville 47712; Charles A. Bonsett, M.D., 6133 E. 54th Place, Indianapolis 46226.

Business Manager: Donald F. Foy

3935 N. Meridian, Indianapolis, Ind. 46208

Managing Editor: Martin T. Badger

Editorial Board:

	Term Expires
Steven C. Beering, M.D., Indianapolis	Dec. 31, 1978
Paul S. Rhoads, M.D., Richmond	Dec. 31, 1978
Elton Heaton, M.D., Madison	Dec. 31, 1979
Rodney A. Mannion, M.D., La Porte	Dec. 31, 1979
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1980
Wei-Ping Loh, M.D., Gary	Dec. 31, 1980

be scorned—the point is that they should never be made compulsory. Voluntary actions in such matters are and should be encouraged by physicians. In fact, in instances where clinical indications are equivocal, careful clinicians either suggest or eagerly welcome consultation.

The experience of Blue Cross-Blue Shield of New York certainly illustrates that voluntary second opinions are to be encouraged—for the comfort of the patient and his physician. Second opinion function as a money saver or as a prevention of unnecessary surgery is highly debatable.

Editorial Notes . . .

Recombinant DNA researchers report that bacteria have been induced to produce insulin through new gene transplant techniques. The American Diabetes Association is watching this carefully. There is a possibility that, with an increase in the number of insulin-dependent diabetic patients, the present sources of insulin may not be sufficient in the future. Also, patients who are sensitive to animal insulin presumably would not be sensitive to bacterial insulin.

The most popular sport among physicians who exercise regularly is jogging. Next are tennis and swimming. Golf is not as popular a doctor sport as is generally believed and commented on—and maybe it never

was. Only 10.7% of the respondents in an AMA poll said they were golfers. More importantly—only 18.2% say they smoke; the percentage was 30 ten years ago.

Unconventional working hours have side effects. Like digestive troubles, increased alcohol use, infringement of sexual activities and a tendency to have more accidents than regular workers. The Stanford Research Institute reports that those on rotating shifts have the most trouble. Especially those who rotate shifts every 30 days. Stanford found that the circadian rhythms require three or four weeks for adjustment. So—those who change shifts on a monthly basis are in the adjustment phase all the time. The people who adjusted most easily were the same ones who enjoyed their work the most.

The AMA has a new Department of Consumer Relations, formed to identify and resolve problems of concern to the medical care consumer. Consumer groups will be asked to outline special needs and wishes in medical care. In turn the AMA will provide consumers with information about the health care system. It is believed that the new activity will provide better information for the consumer public and will also achieve greater consumer involvement in the task of lowering health expenditures. A side effect may be better physician-patient relationships.

Reflections . . . by the chairman of a Surgical Audit Committee

MORRIS S. FRIEDMAN, M.D.
South Bend

Having served as chairman of a Surgical Audit Committee for the past year, I have been reflecting on surgeons, what surgeons do, and what they try to do, and what is actually accomplished; what their responsibilities are and how they place on record the miracles which have been wrought in the operating room. My reflections are best expressed in the immortal words of the poet.

In reflecting upon the skill of the surgeon, we read what the poet has written:

*"Surgeons must be very careful
When they take the knife
Underneath their fine incisions
Stirs the culprit—Life! (1)*

We, as surgeons think of honor in surgery, and as surgeons we strive to do what is honorable, but the immortal bard asks:

*"Can honor set to a leg? No.
Or an arm? No.
Or take away the grief of a wound?
Honor hath no skill in surgery" (2)*

We say that surgeons strive to do what is honorable and in doing so are not faint of heart. The scalpel in the surgeon's hand is an instrument of skill. What about the pen in his hand? Does he use it as well? The poet has written:

"The pen is mightier than the sword." (3)

And, say we, that what the knife has done, the pen should place on record.

Finally, the importance of the written word is nowhere expressed better than in the words of the poet:

*"The moving finger writes and having writ
Moves on: nor all your piety, nor wit
Shall lure it back to cancel half a line,
Nor all your tears wash out a word of it. (4)*

REFERENCES

1. Emily Dickinson
2. William Shakespeare—*Henry IV*
3. Edward Bulwer-Lytton—*Richelieu Act II*
4. Edward Fitzgerald—*The Rubaiyat of Omar Khayyam*

Special Communication

National Cancer Program

Cancer and Estrogen Use

ARTHUR C. UPTON, M.D.
Director
National Cancer Institute

Millions of women are taking estrogen, in **M**oral contraceptives or as replacement therapy after menopause. It is important for these and other women to know of recent studies linking cancer and estrogen use. For some women, the cancer risk associated with estrogen may outweigh its benefit as a means of preventing unwanted pregnancy or of relieving symptoms of menopause.

The use of estrogen during or after menopause has been linked with cancer of the uterus. Studies have shown that women taking estrogen for menopausal symptoms have roughly 5 to 10 times as great a chance of developing uterine cancer as women who take no estrogen. The risk of uterine cancer increases with duration of estrogen use and seems to be greater when larger doses are taken.

In addition, one study has suggested that use of menopausal estrogen may increase the risk of breast cancer 10 to 15 years after it is

first taken. Particularly high breast cancer risk was noted in estrogen users who had benign breast disease.

Estrogen taken during early pregnancy may seriously harm the offspring. The estrogen diethylstilbestrol (DES), prescribed at one time to prevent miscarriage, has been associated with vaginal or cervical cancer years later in some female offspring. The risk of cancer from DES exposure before birth appears to be small. However, noncancerous vaginal irregularities and minor cervical changes appear frequently in DES-exposed daughters, and abnormalities of the urinary and sex organs have been reported in DES-exposed sons.

Scientists have no direct evidence that oral contraceptives further enhance a DES-exposed daughter's risk of cancer. However, since such enhancement has some basis in theory, DES daughters might be advised to choose other methods of birth control. If they do choose to

use oral contraceptives, DES daughters should be examined frequently.

A question has been raised as to whether mothers who took DES are themselves at an increased risk of cancer of the breast or sex organs. The Assistant Secretary for Health has formed a Task Force to evaluate available data on this and other health issues associated with DES. The Task Force will submit action and research recommendations to the Assistant Secretary after its review of the data.

Laboratory studies have shown that when certain animals are given estrogen for long periods, cancers may develop in the breast, cervix, vagina, and liver.

Although scientists have no conclusive evidence that cancer is being caused by oral contraceptives on the market today, one study has suggested that these pills have increased the risk of breast cancer in women with benign breast disease (noncancerous nodules or cysts), and other studies have found an increased rate of early cervical cancer in groups of women using oral contraceptives.

A few cases of cancer of the liver have been reported in women using oral contraceptives, but it is not yet known whether the drug caused them. Oral contraceptives do cause, although rarely, a benign (noncancerous) tumor of the liver. These tumors do not spread, but they may rupture and cause internal bleeding which can be fatal.

Sequential oral contraceptives, no longer marketed in the United States, have been implicated as a cause of uterine cancer. The use of sequential oral contraceptives involved taking estrogen alone for a number of days, then

with progestogen for several days. Oral contraceptives on the market today contain either an estrogen-progestogen combination or progestogen alone. The former are more commonly used.

The Food and Drug Administration requires that a special brochure accompany each prescription of estrogen. The brochure recommends that users of menopausal estrogen be monitored closely by their doctors, that they use estrogen only as long as necessary, and that they take the lowest dose that will control symptoms.

The Food and Drug Administration now requires that a new brochure also accompany each prescription of oral contraceptives. The new brochure, in addition to explaining other risks, warns that oral contraceptives should not be used by women with known or suspected cancer of the breast or sex organs, pregnant women, or those who suspect they are pregnant. The brochure advises women with benign breast disease or a family history of breast cancer to see their doctors frequently for a cancer examination if they elect to use oral contraceptives instead of another method of birth control.

All women taking oral contraceptives or menopausal estrogen should examine their breasts monthly for lumps or changes in appearance that may be warning signs of cancer. An illustrated booklet giving step-by-step instructions in breast self examination is available without charge from the Office of Cancer Communications, National Cancer Institute, Bethesda, Maryland 20014.

A Commentary

A Good Death

GEORGE F. WILL
Newsweek*

As all rivers flow to the same home, the sea, all lives reach the same end, death. But in a modest residential neighborhood south of the Thames, Dr. Cicely Saunders and her colleagues at St. Christopher's Hospice in London are demonstrating that some ways of dying affirm and enhance life. Saunders, 59, a gray-haired 6-footer, radiates the determination of one who hears birds chirp, leaves rustle and people say "It can't be done," and regards it all as just sound, mere music of nature. She is nurse, social worker, physician, and founder of St. Christopher's. As a hospice it provides care to terminally ill patients and their loved ones. Its primary purpose is to alleviate chronic pain. Families are treated as units and cared for in bereavement.

Perhaps not until this century did the average visit of a patient to a doctor do more good than harm. But now medical proficiency, while making living better, is making dying more problematic. Medicine should prolong life, not the process of dying. There comes a point in a degenerative disease when further "aggressive" treatment would intensify the patient's suffering without substantial benefit. Then concern for the patient should become concern for a dignified death, for palliative

care for symptoms and needs. This point is difficult to determine because much is unknown about the behavior of advanced malignant diseases. But the point must be determined.

Treating the Doctor

Saunders believes that doctors treating terminal cancer frequently are concerned too much with the disease process and too little with the patient as a person. "It seems that we first learn how to do things and only later when to do them." It is not always obligatory to use every medical technology as long as possible. For example, doctors should "consider what has been done to a patient who dies in the isolation of a laminar flow room, perhaps unable to touch another person's hand for the last weeks of his life." At some point in terminal cases such measures as chemotherapy, radiation and surgery could be described as treating the doctor, not the patient. Before recent medical advances, doctors had little technology to give, so they gave much of themselves at bedside. Today, when mistakenly prolonged attempts at cures are at last abandoned, many doctors desert the dying, who are left unsupported at the most demanding point of their illnesses.

Dying of a prolonged disease is less an event than a difficult process which, like birth, re-

*Copyright 1978 by Newsweek, Inc. All rights reserved. Reprinted by permission.

quires understanding help. But understanding is scarce, not only because death is a mystery from which people flinch, but because it no longer is a reality with which people are acquainted. Until recently, death was woven into the fabric of life. A rural death was a village affair, and the impersonality of cities was tempered by large Victorian homes where grandparents died with grandchildren at bedside. One reason that people had large families was that many children died of diseases no longer feared. Today life is healthier, families are smaller and dispersed. And death is too remote to be readily conceivable.

Unremitting Pain

St. Christopher's is not just for the dying (there is a wing for the frail elderly) but 90 per cent of those admitted do not go home. The mean length of stay is twelve days. All but about twenty of the more than 600 persons who died there in 1977 died of cancer. St. Christopher's also is a teaching and research facility in the field of terminal care. Its premise is that no patient must remain in chronic pain. Its purpose is *efficient* loving care, hard medicine with a humane dimension in the treatment of all aspects of pain, physical, social, emotional and spiritual. Seventy per cent of St. Christopher's patients are on powerful analgesics, usually morphine taken orally, every four hours, in doses suited to each patient's requirement for keeping pain from breaking through. No patient is anxious about adequate medication, or unbearable pain.

Hospices here and in the U.S. are an answer to demands for euthanasia (meaning not the patient's legal right to demand withdrawal of life-support treatment, but the right to demand a killing act). Support for euthanasia legislation derives, in part, from the mistaken fear that doctors are obligated to prolong life with all available technologies, however severe the ordeal and cost, and the mistaken fear that unremitting pain in terminal diseases, especially cancer, is unavoidable. With hospice care as an alternative, there would be little demand for euthanasia. Without the hospice alternative, legalization of euthanasia would exert vicious pressure on people who are old and frail and believe society does not think much of them. When incurably ill, such people would think of an administered death as the only alterna-

tive to terrible suffering for themselves and terrible cost to their families, so their "right to die" would come to seem like a "duty to die."

Saunders speaks of "a positive achievement in dying" when terminal illness is "a time for reconciliation and fulfillment for the patient and his family, and may well be the most important period they spend together." Remember, she is a professional, not a sentimentalist, and she has earned the right to speak of dying as she sees it daily. Aside from sophisticated pharmacology, St. Christopher's specialty is simple words and gestures. The dying and those who attend them struggle, Saunders says, to make what T.S. Eliot called "a raid on the inarticulate." Patients' needs, she says, are summed up by the words "watch with me," meaning: "be there."

The hospice is a therapeutic community within the community, helping the dying to live until they die and helping families to live on. At weekly staff meetings members brief one another about patients in the hospice and as many at home, and about the grieving. A recent meeting was led by a remarkably poised, tranquil and businesslike young woman with that glowing complexion that is a blessing of life in a misty nation whose genius is not expressed in central heating. Saunders says, off-handedly, that the young woman, who radiates health and serenity amidst distress, "is just a very good English nurse." In Saunders's pride you sense the steel that made another English nurse, Florence Nightingale, such a force for improvement. St. Christopher's staff generally has the placidness of a gentle river which, over time, cuts canyons in granite.

Finely Touched Spirits

In her masterpiece "Middlemarch," Mary Ann Evans (George Eliot), another extraordinary English lady, said of "the finely-touched spirit" Dorothea: ". . . The effect of her being on those around her was incalculably diffusive: for the growing good of the world is partly dependent on unhistoric acts . . ." If the good of the world is growing, the hospice movement is one reason. It is a result of the concentrated intelligence and charity of the finely touched spirits at St. Christopher's, and their predecessors and colleagues around the world.

ANCEF[®]
brand of sterile
CEFAZOLIN SODIUM
GETS TO THE SITE



**OF SERIOUS
RESPIRATORY INFECTIONS**

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported:

Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocytopenia and positive direct and indirect Coombs tests have occurred.

Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported.

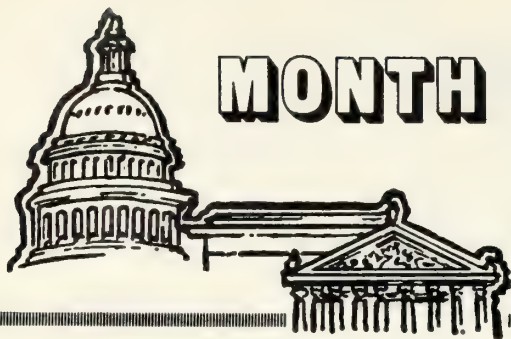
Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

**ANCEF® IV
IM**
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)
Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

The American Medical Association has supported the overall goals of the wide-ranging disease prevention-health promotion bill introduced by Sen. Edward Kennedy (D-Mass.).

"Basic to success must be a major and continuing effort to educate the American people in healthful lifestyles and the importance of preventive medicine," testified Lowell H. Steen, M.D., a member of the AMA Board of Trustees. "Because results of such activities will not be visible overnight, we recommend a long-term commitment to these endeavors," said Dr. Steen.

Consideration of the bill now is "propitious," since public attention can be focused on the health issues to be considered at the conference "Focus on Positive Health Strategies," jointly sponsored by Kennedy and the AMA, Dr. Steen noted. The conference was held in July.

The bill provides a new program of Federal formula grants to states to assist them in meeting the costs of planning and providing health services. These state programs would be directed at reducing the five leading causes of mortality within the state through systems of early detection, screening and prevention of these conditions. A state could also receive formula funds for programs designed to reduce the five leading causes of morbidity within the state.

Special project grants would also be available for: (1) treatment of hypertension; (2) immunization of children; (3) community fluoridation programs; (4) prevention of illnesses caused by environmental factors; (5) prevention of rodent-borne diseases; (6) physical fitness activities; and (7) lead-based paint poisoning prevention.

Dr. Steen said the AMA is pleased that the states would have a major role in determining priorities for the disposition of funds. "We have long stressed the importance of state and local action in health matters and we are encouraged by this proposal."

The proposed level of funding might not be sufficient to reduce the rates of mortality or morbidity in a state effectively, Dr. Steen said. "It would indeed be unfortunate for Congress to develop a major disease prevention initiative, yet to fund in inadequately so that the effort might not get off the ground." He suggested that initially funds be concentrated on disease prevention programs.

Dr. Steen said programs such as those anticipated in the bill could substantially improve health, but "we should not be deceived into believing that these programs are a cure-all. Basic to success must be a major and continuing effort to educate the American people in healthful lifestyles and the importance of preventive medicine."

* * * * *

Immediately following the Supreme Court decision in the Bakke case, C. H. William Ruhe, M.D., AMA's senior vice-president, made these comments on behalf of the Association:

The Supreme Court ruling seems to permit medical schools to continue using race as one factor in determining admission criteria. We hope that medical schools will, therefore, continue to use those selective admissions programs designed to increase the numbers of minority students. It is only through these types of programs that we can hope to increase the numbers of minorities in the practice of medicine.

The American Medical Association has long been in support of programs designed to increase minority representation in medical schools and in the practice of

CONTINUED ON PAGE 741

Dx: recurrent herpes labialis

*Herpecin-L
Lip Balm
Sig: q. i.
as needed*

OTC
See PDR for
Product
Information

HERPECIN-L

For samples, write Dept. J at:

CAMPBELL LABORATORIES, INC.
P.O. Box 812, FDR, N.Y., N.Y. 10022

Available at all Haag Drug Stores and
other select pharmacies.



ROCKWOOD

INSURANCE COMPANY OF INDIANA

Professional Liability Insurance Specialists

Physicians, Surgeons, Dentists

Hospital Professional Liability

Represented by:

Health Care Provider Insurance Agency, Incorporated

INDIANAPOLIS . . . Hadley-Mahoney Co., 3640 N. Washington Blvd. 46205
(317) 924-5331

MICHIGAN CITY . . . Lindenmeyer Insurance Associates, Inc.
801 East Eleventh Street 46360
P.O. Drawer C
(219) 879-7301

SEYMOUR Wienco, Inc., Room 20, Vehslage Building
P.O. Box 518 47274
(812) 522-2931

SOUTH BEND Hepler-Smith Insurance, Inc.
511 West Colfax Avenue
P.O. Box 1875 46634
(219) 232-4889 (Toll Free 1-800-552-2910)



Forget Everything

you ever knew
about borrowing

Money

Introducing a new loan:

THE PROFESSIONAL

so unique that we have over \$4,000,000.00 in personal loans made to Physicians and Dentists.

Unique Features...

- **PAY ANY AMOUNT ANY DAY OF THE MONTH.**

In good times, pay more. During slow periods, pay the minimum.

- **WE MAKE HOUSE CALLS.**

A collect call is all that's necessary to begin processing your loan. We will come to your home, office or hospital to close your loan at your convenience.

This confidential loan is made for any good purpose . . . long term or short . . . \$10,000 to \$50,000. An interest-bearing loan, it can be repaid in varying amounts and on any day. You pay only for the time you use the money. Call today.

PROFESSIONAL LOAN DIVISION

Ask for Colin G. Haza
Assistant Vice President

110 East Washington Street
Indianapolis, Indiana 46204
Phone (317) 631-1311

Indianapolis

**Morris
Plan**

Get

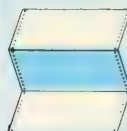
PAID.

Time and time again, Medical Data Systems® users report: (1) substantial reductions in outstanding accounts receivable, (2) accelerated cash flow, (3) elimination of missing charges, and (4) faster turn around on third-party claims. Data processing services are more than fancy reports. MDS can be the difference between getting paid and not getting paid. And that's a good business basic.

S-Tek Computer Services —
The Data Processing Tailors

MEDICAL DATA SYSTEMS®

Call or write our Sales
Department for more information.



**S-Tek
COMPUTER SERVICES, INC.**

P.O. BOX 328 TERRE HAUTE, IN 47808 812-232-1385

Medical Data Systems®, a registered
trademark of S-Tek Computer Services Inc.

MONTH IN WASHINGTON

CONTINUED FROM PAGE 738

medicine. This position was reaffirmed last week in St. Louis at the Association's Annual Meeting through acceptance of a manpower report of the AMA Council on Medical Education. The report addresses the issue of "Black and Other Minority Group Physicians" with the opening statement: "The inadequate representation of minority groups in the medical profession and in medical school enrollments remains of concern to the AMA."

* * * * *

The House Ways and Means Health Subcommittee has approved the Clinical Laboratory Improvement Act.

The new provision would prohibit percentage contracts with hospital-based physicians unless the charges were "reasonable" in terms of what the hospital would have paid for such services if the physician had been employed by the hospital, and the cost of other "reasonable expenses" incurred by physicians in performing the services. This provision would be applicable to clinical laboratories outside of a hospital.

The Health Subcommittee also approved language which provides that "if the Joint Commission on Accreditation of Hospitals imposes standards for hospital laboratories that are at least equivalent to the national standards, the Secretary of HEW (or the state, in the case of a state with primary enforcement responsibility) could deem a laboratory in a JCAH-accredited hospital to be in compliance with the national lab standards."

The CLIA bill extending federal regulations over clinical labs has passed the Senate and the House Commerce Committee which sent it to Ways and Means. All the bills are similar. The physician office exemption in Senate was not mandatory. The House exemption is automatic for groups of five or fewer, or for any size group if tests are done by the physicians themselves.

* * * * *

Rep. Paul G. Rogers, 57-year-old Florida Democrat whose name is often synonymous with health legislation on Capitol Hill, has decided to quit the House after 12 terms.

Chairman of the House Interstate and Foreign Commerce Committee's Subcommittee on Health and Environment, Congressman Rogers has gained the reputation of a knowledgeable, tough but always fair, prime mover of health legislation in the House.

Facing no important opposition at home (parts of Broward and Palm Beach counties), Rogers said he merely wants to try "a change of career" and is "open to offers".

Candidates to succeed him include Reps. David Satterfield (D-Va.), Richardson Preyer (D-N.C.) and James Scheuer (D-N.Y.), ranking members of the subcommittee.

* * * * *

The House approved a \$55 billion money bill for the Health, Education and Welfare Department, both more and less than the Administration requested.

The confusion arose because the House added \$641 million to specific programs, but also voted a \$1 billion general chop that may prove meaningless. Another \$17

billion of HEW programs must go through the appropriations mill, since the House is deferring action on these programs until their extended authorizations are approved later this year.

An amendment denying federal funds for Medicaid abortion payments unless the mother's life is imperiled was adopted by the House, ensuring still another controversial go-around with the Senate on the emotional issue.

The bill is now in the Senate awaiting action.

The rather muddled budget situation saw HEW secretary Joseph Califano writing letters to lawmakers exploring "meat ax" cuts on the one hand and threatening a Presidential veto for too fat a bill on the other.

The \$1 billion "out" in effect was a challenge to Califano's report earlier this year charging that fraud, waste and abuse is costing the Department more than \$6 billion a year. If that's the case, the House was saying, then at least \$1 billion ought to be saved through cracking down on the waste. However, no specific program reductions were required, nor will any services apparently be cut.

Much of the increase over the Carter budget voted by the House was for health manpower and general education outlays, which the Administration wanted trimmed. The National Institutes of Health received \$305.7 million more than the budget figure.

Many of the health program appropriations were sought by the American Medical Association which had urged that key programs, especially in the health manpower and national health service corps areas, not be slashed.

Rep. Robert Giaimo, (D-Conn.), chairman of the House Budget Committee, recently told the AMA that "with a few notable exceptions, we adopted the same strategy you outlined . . . for funding health programs."

"With respect to programs which support health care services, training of health manpower and biomedical research, the committee recommended adding \$250 million to the President's budget request," said Giaimo. "This total is in line with your recommendations, with the exception of the health professions education program for which you suggest fairly sizeable increases."

The Budget Committee chairman also said in a letter to James Sammons, M.D., AMA executive vice-president, that "I am pleased on the whole that the AMA recognizes the need to constrain the rising costs of health care programs and has joined with hospital associations to reduce the rate of increase in hospital costs."

* * * * *

The F. Edward Hebert Naval Regional Medical Center in New Orleans is a \$22 million white elephant that should be abandoned by the Navy, reports the General Accounting Office. The Defense Department agrees with the findings.

The GAO, Congress' investigative agency, said the westbank installation has a daily average patient load of 23, less than 10% of the 250-bed capacity. The potential for increasing the work load significantly "is virtually nonexistent," said GAO.



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article continues my discussion of the gift and estate tax sections of the Tax Reform Act of 1976 (TRA) and the proposed changes which are in the Technical Corrections Bill (TCA).

I shall now turn my comments to the important relationships which exist between the amount of the gift tax marital deduction which a decedent deducted during the decedent's life and the maximum estate tax marital deduction to which a decedent may be entitled at death. Prior to the TRA, the gift tax marital deduction and the estate tax marital deduction were independent of each other. That is, under prior law, an individual could deduct any amount of the gift tax marital deduction during the individual's life, and, the decedent would still be entitled to the prior full estate tax marital deduction at death.

Now, after the TRA, an individual's use of the gift tax marital deduction may reduce the individual's use of the new estate tax marital deduction. That is, section 2056(c) (1) (B) provides that, in certain cases, the new estate tax marital deduction must be reduced by a portion of the value of the transfers which a decedent has made to the decedent's spouse, as gifts, during the decedent's life.

That is, after the TRA, a decedent's maximum estate tax marital deduction must be reduced by: the excess of the amount of the gift tax marital deduction which the decedent deducted after 1976 over the total value of the gifts which a decedent gave to the decedent's spouse after 1976. For the purpose of computing the "total value" of the gifts which a decedent has made to a decedent's spouse after 1976, the \$3,000 exclusion for gifts of present interests (under section 2053) is, in general, ignored.

The computation of this reduction is as follows.

1. First, there must be a determination of the maximum amount of estate tax marital deduction to which the decedent would be entitled, under the general rules which I have discussed in prior articles. That is, the first step is to compute which amount is greater between: \$250,000; and, 50% of the decedent's adjusted gross estate.

2. Second, a determination must be made as to the value of the gifts which the decedent made during the decedent's life, and after 1976.

3. Third, the maximum estate tax marital deduction must be reduced by the excess of: the amount of the gift tax marital deduction which the decedent deducted after 1976 over 50% of the total value of the gifts which the decedent made to the decedent's spouse after 1976.

The computation of the reduction of the estate tax marital deduction may be illustrated by the following examples.

Example One

Assume that a decedent made gifts to the decedent's spouse, after 1976, in the amount of \$53,000. In this case, the decedent would have been entitled to a gift tax marital deduction in the amount of \$50,000 (\$53,000 less \$3,000 equals \$50,000, and, the base gift tax marital deduction of \$100,000 eliminates the \$50,000 balance). Further, because this gift tax marital deduction of \$50,000 exceeds 50% of the total value

of the gifts which the decedent made to the decedent's spouse (50% of \$53,000 equals \$26,500), the decedent's maximum estate tax marital deduction must be reduced by the excess of \$50,000 over \$26,500, which equals \$23,500.

Example Two

Assume that a decedent made gifts to the decedent's spouse, after 1976, in the amount of \$103,000. In this case, the decedent would have been entitled to a gift tax marital deduction in the amount of \$100,000 (\$103,000 less \$3,000 equals \$100,000—which equals the base gift tax marital deduction). And, because this gift tax marital deduction of \$100,000 exceeds 50% of the total value of the gifts which the decedent made to the decedent's spouse (50% of \$103,000 equals \$51,500), the decedent's maximum estate tax marital deduction must be reduced by the excess of \$100,000 over \$51,500, which equals \$48,500. Thus, while it first appears that the TRA allows such an individual to avoid gift and estate taxation on (at least) \$103,000 of gifts which the individual made to the individual's spouse, during the individual's life, in fact, the individual may be escaping taxation on only \$51,500 of gifts.

Example Three

Assume that a decedent made a gift to the decedent's spouse, after 1976, in the amount of \$153,000. In this case, the decedent would have been entitled to a gift tax marital deduction of \$100,000 (\$103,000 less \$3,000 equals \$100,000—which equals the base gift tax marital deduction). And, the \$50,000 of the gift (\$153,000 less \$3,000 and less \$100,000) would have been subject to gift tax. Then, for estate tax purposes, the decedent's maximum estate tax marital deduction would be reduced by the excess of the decedent's gift tax marital deduction of \$100,000 over 50% of the value of the property, which the decedent transferred to the decedent's spouse. And, the gift tax marital deduction taken of \$100,000 exceeds \$76,500 (50% of \$153,000) by \$23,500, and thus, the decedent's estate tax marital deduction must be reduced by \$23,500.

Example Four

Assume that a decedent made a gift to the decedent's spouse, after 1976, in the amount of \$203,000. In this case, the decedent would have been entitled to a gift tax marital deduction of \$101,500 (\$100,000 base gift tax marital deduction plus 50% of \$3,000—namely, 50% of the excess of \$203,000 over \$200,000). And, the amount of the reduction of the maximum estate tax marital deduction is zero, because the gift tax marital deduction of \$101,500 does not exceed 50% of the total value of the gifts given to the spouse, namely, 50% of \$203,000, which is \$101,500.

Now, what do these four examples illustrate? First, I wish to state that as a drafter of many statutes and an interpreter of more, it personally irks me that the task of drafting the gift and estate tax provisions of the TRA was apparently assigned to

CONTINUED ON PAGE 744

100 mg

250 mg

500 mg



Tolinase[®]

tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

© 1977 THE UPJOHN COMPANY

TAX TIPS

CONTINUED FROM PAGE 742

someone who had never heard of the \$3,000 gift tax exclusion for gifts of present interests (under section 2503). Thus, the following theory (which I shall state) is not quite true—but it is close enough to the truth in order to be useful to explain the basic theory of the computation of the reduction of the maximum estate tax marital deduction.

That is, ignoring the \$3,000 gift tax exclusion, it can be stated that if an individual utilizes the individual's base \$100,000 gift tax marital deduction during the individual's life, then the individual's estate tax marital deduction will be reduced by 50% of the \$100,000, namely, by \$50,000. And, if an individual gives \$200,000 to the individual's spouse, then the individual's estate tax marital deduction reduction will be zero.

To state this another way, if an individual makes gifts of up to \$100,000 to the individual's spouse (that is, up to the base \$100,000 gift tax marital deduction, which is gift-tax free), then the estate tax marital deduction will be reduced by 50% of that amount. And, if the individual gives up to \$200,000 to the individual's spouse (that is, up to the second \$100,000 bracket, which is taxable for gift tax purposes), then the estate tax marital deduction reduction will, itself, be reduced by 50% of these taxable gifts.

To state this still another way, for each \$1 which an individual gives to the individual's spouse and which is eliminated from gift taxation by the base \$100,000 gift tax marital deduction—the estate tax marital deduction is reduced by 50¢. And, for each \$1 which an individual gives to the individual's spouse and which is taxable (because the \$1 or more enters the second \$100,000—and taxable-bracket), the estate tax marital deduction reduction is reduced by 50¢.

These latter general points, concerning the maximum estate tax marital deduction reduction, can be best illustrated by examining the prior four examples which present computations of the reduction.

That is, notice (in **Example One** of the prior examples) that when the individual gave the individual's spouse \$53,000, the estate tax marital deduction reduction was \$26,500. And, when (in **Example Two**) the individual gave the spouse \$103,000, then the estate tax marital deduction reduction increased to \$48,500. On the other hand, when (in **Example Three**) the individual gave the spouse \$153,000, then the estate tax marital deduction reduction decreased to \$23,500. And, finally, when (in **Example Four**) the individual gave the spouse \$203,000 (or more), then the estate tax marital deduction reduction decreased to zero.

Unfortunately, as indicated above, because the drafters of the gift and estate tax provisions of the TRA did not seriously consider the effect of the \$3,000 annual gift tax exclusion on this reduction computation, my first "general" statements are not quite correct. Thus, I might correct these "general" statements in the following way. If an individual makes gifts of present interests, in one taxable year, to the individual's spouse in the amount of \$100,000, then the maximum estate tax marital deduction reduction is not \$50,000, but it is \$47,000 (\$100,000 less \$3,000 equals \$97,000, and \$97,000 less 50% of \$100,000 equals \$47,000). Further, for gifts of present interests—the most common type of gift—the maximum estate tax marital deduction reduction will not exceed \$48,500, and, this reduction will occur when the donor has given, for example, in one taxable year, gifts to the donor's spouse of \$103,000. In this latter case, the gift tax marital deduction is \$100,000 (\$103,000 less \$3,000), and, 50% of the total value of the gifts to the spouse is \$51,500 (50% of \$103,000), and, \$100,000 less \$51,500 equals \$48,500. As you can compute for yourself, a gift of a present interest of over \$103,000 will commence the decrease of the estate tax marital deduction re-

duction until the maximum reduction of the reduction occurs, not at \$200,000, but at \$203,000, at which point, the reduction of the reduction causes the reduction to equal zero. If an individual made a gift of a future interest of \$100,000, in one taxable year, then the maximum estate tax marital deduction would be \$50,000 (\$100,000 less 50% of \$100,000 equals \$50,000).

It is important to note that only the **maximum** estate tax marital deduction is required to be reduced by certain deductions of the gift tax marital deduction. That is, as I stated above, section 2056(c) (1)B imposes the reduction only on the greater of: \$250,000; and 50% of the adjusted gross estate. Thus, if the estate tax marital deduction is, in fact, less than the greater of the \$250,000 or 50% of the adjusted gross estate, then such lesser amount is not reduced by the reduction. For example, if a decedent had an adjusted gross estate of \$800,000 and the decedent's maximum estate tax marital deduction was \$30,000, and the decedent devised \$40,000 to the decedent's spouse, then the decedent would be entitled to an estate tax marital deduction of \$40,000. That is, the maximum marital deduction under section 2056(c) would be the greater of \$250,000 and \$400,000 (50% of \$800,000), which is \$400,000, and thus, the reduction of \$30,000 would reduce the maximum estate tax marital deduction from \$400,000 to \$370,000. However, under these facts, the decedent would only be entitled to an estate tax marital deduction of \$40,000, namely, the amount which the decedent devised to the decedent's spouse, and this latter amount need not be reduced by the \$30,000 reduction.

The TCA addresses two important points concerning the reduction of the maximum estate tax marital deduction.

First, the TCA proposes that no reduction of the estate tax marital deduction may be made for gifts by a donor to the donor's spouse if such gifts were not required to be reported for gift tax purposes, because the gifts were excluded by the \$3,000 annual gift tax exclusion for gifts of present interests (under section 2503). This potential reduction of the estate tax marital deduction could occur after a donor has used all of the donor's base \$100,000 gift tax marital deduction but the donor has not completely eroded the section \$100,000 gift tax bracket. Thus, in such a case, as long as a donor's gifts to the donor's spouse do not exceed the \$3,000 annual gift tax exclusion, the TCA provides that no reduction of the estate tax marital deduction will be allowed for such gifts (of \$3,000 or less) to the donor's spouse.

Second, the TCA proposes to amend section 2056(c) so that gifts which the decedent made to the decedent's spouse and which are includible in the decedent's gross estate, for estate tax purposes under section 2035, are not taken into account for the purpose of the estate tax marital deduction reduction. That is, if a decedent makes a gift to the decedent's spouse and the decedent offsets the gift with some of the decedent's base \$100,000 gift tax marital deduction, and then, the gift is includible in the decedent's gross estate, for estate tax purposes, so that the use of the gift tax marital deduction did not really benefit the decedent (except to delay the payment of the tax), it would be unfair to require the decedent to reduce the decedent's maximum estate tax marital deduction because of the gift tax marital deduction which did not benefit the decedent.

If you would like a copy of my complete discussion of the major gift and estate provisions of the TRA and the TCA, you may obtain one (along with several other articles concerning the TRA) by writing: R & R Newkirk, Legal Department, P.O. Box 1727, Indianapolis 46206.

A large, thick, black L-shaped graphic that starts at the top left, goes down, and then turns right to point towards the bottom right corner of the page.

COMPUTER?

BEFORE YOU MAKE A DECISION
TALK TO A SPECIALIST.

GENERAL MICROCOMPUTER

COST EFFECTIVE
MICROCOMPUTER SYSTEMS
TAILORED TO THE SPECIFIC
NEEDS OF YOUR PRACTICE

GENERAL MICROCOMPUTER, INC.
1657 COMMERCE DRIVE
SOUTH BEND, INDIANA 46628
(219)-233-9171

Scaphoid Bone

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

The wrist bone that most frequently presents with an occult fracture, not found by x-ray until 10 to 14 days from the time of injury, is the "scaphoid bone." Hidden fractures in the waist of the "scaphoid" can produce an avascular necrosis of the distal half of the "scaphoid" if they are not immobilized, and this fact is a worrisome problem to many clinicians who treat patients who break their falls by landing on their hands.

For some time now, in order to have clarity, the anatomists have named this bone the "scaphoid bone" and have reserved the term "navicular bone" for a bone in the ankle. "Navicular" is of Latin origin, and "scaphoid" is of Greek origin. Both words when translated into English mean "boat shaped." The purpose of naming the "scaphoid bone" in the wrist differently from the "navicular bone" in the ankle is a good one. It's to avoid confusion. It is better not to have two bones in the body carrying the same name.

We should follow the anatomists' lead and use "scaphoid" for the bone in the wrist and "navicular" for the bone in the ankle to avoid confusion from having the same name for two different bones. But it is seldom done clinically. Habits are slow to change.

Disease

The other day a physician asked me, "Is there any pathology?"

I did a double take. Then I told him that I found no evidence of disease.

The reaction was a natural one for me because one of my teachers had insisted in medical school that we use the word "disease" rather than "pathology" when we are talking about a destructive process. "Pathology" of course means "the study of disease," and it is inaccurate to ask if there is pathology or "a study of disease" present when our question really is, "Is there disease present?"

I hear this word "pathology" commonly misused by physicians, and it muddies the waters. Why substitute an inaccurate four-syllabled Greek word for the easy word "disease" that has only two syllables and is clearly understood?

I think we should use the word "disease," not "pathology," unless we are actually talking about the study of disease or the work of a pathologist.

Brief Summary of Prescribing Information Combined TEGOPEN® (cloxacillin sodium) Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100; 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.



BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



IN THE INDIANAPOLIS AREA, STAPH RESISTANCE HAS NOW REACHED 87%.

resistance to penicillin G among community-acquired
staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER **TEGOPEN[®]** (cloxacillin sodium) “THE PENICILLIN OF TODAY”

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary
for prescribing information.



AUXILIARY REPORT

Ruth (Mrs. G. Beach) Gattman
President, ISMA Auxiliary

This month's Auxiliary Report was prepared by Charlotte (Mrs. Abner P.) Bennett of Evansville, our president-elect.

"Meet me in St. Louis, Louis" was the refrain that kept going around in my head when I learned that was where our annual meeting was to be held. Those words—accompanied by the toot of the steamboats, the winding Mississippi River, the soaring Gateway Arch—were part and parcel of an exhilarating and stimulating four days spent at the AMA Auxiliary Convention held in St. Louis, Missouri June 18 through 21.

Values and choices, the theme chosen for her 1977 inaugural address by Mrs. Chester L. Young, AMA Auxiliary president, were re-examined and found to have been maintained and implemented in auxiliary projects during her tenure in office.

The immunization awareness program, with its hopscotch courts and radio and TV spot announcements, has been highly successful. Presentation of a record-breaking check to AMAERF for \$1,577,366 represented a whopping \$64,800 increase over last year. Seventy-thousand loans representing \$85,000,000 as well as unrestricted grants to medical schools have been made to date to help provide financial aid to medical students and residents.

The first issue of *Horizons*, a newsletter geared to resident physicians' spouses, made its debut this May. It is hoped that this newsletter will create an awareness of the AMA Auxiliary and its programs, with the long-range goal of recruitment of future members.

In the near future members will derive direct benefits from the auxiliary when discounts will be offered to the membership on Hertz rentals and nurses will be able to receive continuing education units for attending seminars provided at the AMA and Auxiliary meetings under the auspices of the American Nursing Association.

Our incoming president, Mrs. Manuel Bergnes, keynoted her inaugural address by emphasizing, "We, who are members of the AMA Auxiliary, believe in the power of the volunteer to effect meaningful change." She also stated that we must use volunteer power, singly and in our group efforts, to protect the reputation of the medical profession. She re-emphasized that health promotion through modification of life style, good nutrition, exercise and utilization of professional preventive health services is the way in which the quality of life can be improved and the spiraling cost

of medical care be reduced. Cost effectiveness can then become a reality without the intervention of government. Auxiliaries attending the 1978 Fall Confluence in Chicago will hear more about the Hospice Program—a prime area of volunteer involvement, as well as education programs for people who share their homes with aging parents.

Dr. John Budd, AMA president, addressing the auxiliary, stated, "We must quit apologizing for things we don't do—and emphasize what we do well." While the government is concerned with the cost of medicine—medicine is concerned primarily with quality and patient access to care, and secondarily with cost.

An interesting theory was proposed by Eliot Janeway, economist and financial lecturer. He suggested that the medical community has within its power the ability to modify the current inflation by judicious exportation of its medical expertise and facilities to oil-producing countries whose exorbitant oil prices have fueled our current problems. Bjorn Secher, an author and speaker who gave the keynote address on Personal Development and Management, was exciting and dynamic as he stressed that positive attitude is the most important attribute in success. He was the embodiment of his philosophy—enthusiastic and full of axioms. Several of his quotes were intriguing—"As you think, so you are," "Success is luck, ask any failure," "Your goal becomes your potential worth."

The educational programs presented jointly with the AMA council on continuing education for physicians were of great interest to auxiliary members as well as to the physicians. The Joys and Sorrows of Medical Marriage panel discussion filled the convention hall. The danger signals in medical marriages were discussed, as were the frightening statistics that divorces among physicians are much more common than among the general population.

Relaxation was part of our stay as we again had the pleasure of serving as hostesses at the ISMA hospitality suite. Our 500 checkered flags were eagerly sought after by, not only auxiliary delegates, but AMA conventioners as well. We shared with the ISMA our pride at the installation of our own Marge Smith as treasurer of the American Medical Association Auxiliary.

It was a privilege to represent the ISMA Auxiliary at the AMA Auxiliary Convention.

The Great Laxative Escape



COLACE

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson

PHARMACEUTICAL DIVISION

© 1979 Mead Johnson, Inc. All rights reserved. NJ 07065 USA 270-1

This asthmatic isn't worried about his next breath...

he's active
he's effectively
maintained on

QUIBRON[®]

Each capsule or tablespoon (15 ml) elixir
contains theophylline (anhydrous) 150 mg
and glyceryl guaiacolate (guaifenesin)
90 mg. Elixir: alcohol 15%

- theophylline for effective
around-the-clock
bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R3

Prosperity

From The Journal 50 Years Ago

PRACTICALLY all of the manufacturers of physical therapy apparatus urge physicians to buy ultraviolet machines, infra-red lights, sun lamps and diathermy apparatus on the ground that much money can be made from physical therapy treatment. Few of them say much about the conditions in which physical therapy is indicated, though some of the manufacturers go so far as to say that there is no real or imaginary ailment that isn't benefitted by some form of physical therapy treatment and consequently every patient that comes to the doctor's office can be made a source of profit. Isn't it ridiculous to have the practice of medicine so commercialized? A physician has little or no conscience if he administers a whole lot of useless treatments merely because he can get a fee for doing it. It is quite true that a physician earns his income through the practice of medicine, and he can increase his income by giving real service, but that does not mean that he should be dishonest with himself and with the patient merely because it means adding dollars to his income.

IN July the government announced a new loan of \$250,000,000 running for fifteen years, not callable under twelve years, with interest at 3½ per cent. Inside of three days over a billion had been subscribed, or four times the amount required by the government. Could anything more clearly indicate the confidence of the people in their government securities or prove the enormous amount of money in this country available on demand? The new loan is for the purpose of retiring what is left of the last Liberty loan, and, incidentally, this government, starting out with an indebtedness of over sixteen billion dollars at the close of the last war has paid off all of this indebtedness except about two billion dollars—and yet we hear some people talk about "hard times" and the poverty of the masses. The people in no other country on God's earth are as prosperous and have so many of not only the comforts but the luxuries of life.

JISMA, August 1928

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

1978 Annual Meeting—Oct. 22-25—Clarksville

OFFICERS FOR 1977-78

President—Eli Goodman, 807 High St., Charlestown 47111

President-Elect—James A. Harshman, M.D., St. Joseph Hospital, Kokomo 46901

Treasurer—Arvine G. Popplewell, 3530 S. Keystone, Indianapolis 46227

Assistant Treasurer—Joseph F. Ferrara, 111 S. Water St., Franklin 46131

Executive Committee—John W. Beeler, 1815 N. Capitol Ave., Indianapolis 46202, Chairman; Richard G. Ingram, 206 S. Main St., Montpelier 47359; Joe Dukes, Dugger 47848, Members

Speaker of the House—Lloyd L. Hill, 302 N. Duke St., Peru 46970

Vice Speaker—Lawrence E. Allen, 2009 Brown St., Anderson 46016

Executive Director—Mr. Donald F. Foy



Dr. John A. Davis

'Oh, Doc's a Good Guy'

Dr. John A. Davis didn't waste any time setting up his medical practice in the tiny town of Flat Rock. The day after he completed his internship at Indianapolis' Methodist Hospital—July 1, 1933—he opened his office next to his new home on the farming community's main street.

He didn't get much chance to waste time since that first day as the resident physician until his retirement this past December. As his wife remarked casually, "It was a very, very busy practice." Dr. Davis was graduated from the I.U. School of Medicine in 1932.

Could you call him a country doctor? "Oh, yes!" exclaimed Mrs. Davis.

Although the U.S. had emerged from the horse and buggy days in 1933, there were still some rough spots to handle trying to get to patients deep in the rural areas of the county.

"The phone service was terrible," Dr. Davis commented.

In those early days, the Davises toiled around in a second-hand model A. The affable couple even have a cherished replica of that car that they proudly display to visitors.

As for the highlights of his medical career in the Flat Rock community—"I delivered 3,150 babies and there were some I didn't count . . . I could make it to Shelbyville in 12 or 13 minutes!"

"Alma Trees told me she could time him!" Mrs. Davis laughed. (Mrs. Trees is an o.b. nurse at Major Hospital.)

During those first 10 years of Dr. Davis' career, though, there weren't the fast trips to Major Hospital. He delivered babies at home and often Mrs. Davis was on hand to assist.

Dr. Davis had a two-way radio installed in his car in 1959. That move, of course, saved him considerable time in getting to the next house call or stop without having to drive back to his office. And it was only shortly before retiring that he gave up making house calls.

Along the way, Mrs. Davis, who happened to be a school teacher, got a medical education accompanying the doctor on his numerous calls.

Reprinted with permission from THE SHELBYVILLE NEWS, Shelbyville, Ind. The original article was written by Kris Vawter.

He's a country doctor and, in the early days, he and his wife got around in a second-hand Model A....

One of her vivid memories is lugging along the great big suitcase that held the sterile drapes.

During the war years, the busy Flat Rock practice became even more hectic. Although Dr. Davis enlisted in the Navy, the authorities declared he was essential to the neighborhood.

"Then he really got stuck with long hours!" Mrs. Davis quickly pointed out.

His boundless energy was invaluable. Even with no office person to help keep the appointment book juggled and all other bookkeeping matters straight, Dr. Davis maintained a six-day-a-week practice. (More often it turned into a seven-day-week!) He had morning, afternoon and evening office hours. In general, he was there when patients needed him. The Davis "territory" extended to the far side of Edinburg and the far side of Geneva and included people in Columbus, Shelbyville and Franklin.

The phone still demands the 69-year-old physician's attention. Even during the interview an Indianapolis patient, unaware of his retirement, wanted an appointment. She was a little beside herself wondering where to find a new physician.

As the saying goes, architects rarely live in their own houses and likewise with the Davis family. Mrs. Davis said there were probably two or three times the family needed a physician's attention outside of routine matters. On those occasions, their good friend, the late Dr. W. R. (Dr. Bill) Tindall, was consulted.

Even during summer vacations, Dr. Davis' medical career wasn't far from him. To keep abreast of medical developments, "Doc" spent summer vacations taking medical courses. This "only" involved some 20 years of taking courses offered by the University of Minnesota.

In between times of delivering babies and treating a variety of ailments, Dr. Davis devoted time and energy to his beloved Flat Rock community.

One of his fondest memories of public life was helping organize the Flat Rock Citizens Committee with his friends. The committee had its beginnings around the Davises' kitchen table and the doctor eventually served as the committee's third president.

From 1968 to 1976 Dr. Davis, a Republican, was a Shelby County commissioner. He was vice president of the board of commissioners from 1969-70 and was president from 1971-72.

One wall of a room reflects his lifelong concern for his fellow citizens. Plaques cover practically every square inch of existing space.

His honors include being named Outstanding Citizen of 1961 and, more recently, Sagamore of the Wabash by Governor Bowen. At one time or another the Flat Rock physician belonged to practically all county voluntary health organizations such as the Red Cross and was involved in the State Tuberculosis Association. He is a former member of the Major Hospital and the Shelby County United Fund boards of directors and the Shelby County Board of Health.

Dr. Davis also belongs to the Flat Rock United Methodist Church, Farmers Masonic Lodge 147, Scottish Rite, Murat Shrine and Elks Lodge and is an honorary director of the Farmers National Bank. He is past president of the Shelby County Chamber of Commerce. He is a member of the Indiana State Medical Association and the American Academy of Family Physicians.

As for the future, Dr. Davis is "definitely NOT" (his wife's words) the rocking chair type. Gardening, fishing, canoeing and—in season—IU football will occupy his time. The Davises also have two daughters and three grandchildren.

The Davises have had a few "nibbles" about the Flat Rock practice from physicians wishing to locate in the Columbus area. But the office next to the white house is now quiet. Remarkably a doctor's family has always lived in that 100-year-old house.

On the wall of the living room hangs a pastel portrait of the doctor, done by a terminally ill patient, which the Davises cherish. Another patient of the doctor's recently remarked, "Oh, doc's a good guy!" A simple but complete tribute for the physician and the man.

NOTES FROM DOWN UNDER



DOUGLAS F. JOHNSTONE, MD
Indianapolis

Urologic Complications of Analgesic Abuse

Excessive use of various analgesics has been conclusively linked to an increased incidence of an interstitial nephritis, which may be progressive in terms of functional renal impairment, and the presence of papillary necrosis. A similar association with the development of transitional cell carcinomas of the renal pelvis is also known to occur. Likewise, occurrence of transitional cell neoplasms of the urothelial epithelium, particularly of the renal pelvis area, is established. Solitary and multiple renal pelvic tumors are relatively com-

mon in Australian females. This contrasts with the situation in the United States where males are more frequently affected, and overall incidence is lower. A series of patients were reviewed and the fact that such patients may present in years following cessation of analgesic abuse and stabilization or improvement in renal function with symptoms or findings due to the development of malignancy underscores the importance of adequate urologic evaluation under such circumstances.

The Systemic Involvement in Scleroderma

A review of a series of patients with scleroderma was evaluated by Dr. A. J. Barnett of Alfred Hospital, Victoria. Clinical symptoms, laboratory findings and x-ray abnormalities were sought. Of the 38 patients studied, digital ischemic symptoms were present in all. Roughly two-thirds had upper gastrointestinal and joint symptoms. Respiratory, small bowel, cardiac and symptoms of depression were each observed in approximately one-third of patients. The most common laboratory abnormality was an elevated sed rate, seen in 55%.

Various auto-antibodies and serum immunoglobulin abnormalities were each seen in about one-third of the patients. Depressed creatinine clearance was seen in 68%. X-ray changes included abnormal hand films, generally erosion of the tufts of the terminal phalanges in 82% of cases. Soft tissue calcification occurred in 53%, often when not clinically apparent. In summary, this study tends to confirm the high incidence of systemic involvement in scleroderma that has been noted by most investigators.

Sulfa-Trimethoprim Use in Bronchitis

The majority of acute exacerbations of chronic bronchitis involve *Hemophilus influenzae* or *Streptococcus pneumoniae*. Amoxycillin and the combination of sulfa-trimethoprim are both effective against the majority of these organisms. A trial comparing these two drugs in such patients was undertaken and demonstrated equal effectiveness of the two regimens in producing clinical improvement and reducing sputum purulence and volume. Likewise, relapse rate was similar in the two groups. As the combination of sulfa-trimethoprim becomes accepted therapy for upper and lower respiratory infections in the U.S., this combination may prove useful in

managing acute flareups of chronic pulmonary disease, particularly in those patients allergic or otherwise intolerant to ampicillin related drugs.

REFERENCES

1. Kench, Peter, MB, CH.B.: Analgesic nephropathy complicated by development of transitional cell carcinoma of the renal pelvis and ureter, *Med. J. Australia*, 1977, 2:607-610.
2. Barnett, AJ, M.D.: The systemic involvement in scleroderma, *Med. J. Australia*, 1977, 2:659-672.
3. Tandon, MK, M.D.: A comparative trial of cotrimoxazole and amoxycillin in the treatment of acute exacerbations of chronic bronchitis, *Med. J. Australia*, 1977, 2:281-284.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. / mg. / mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



THE JOURNAL, in cooperation with the Division of Postgraduate and Continuing Medical Education of the Indiana University School of Medicine, offers its readers a Continuing Medical Education program. This is the seventh in a series of articles written for purposes of continuing medical education—produced by the faculty of the School of Medicine and supported by a grant

from its Division of Postgraduate and Continuing Medical Education.

Through reading and following each article carefully and answering the Quiz correctly, one hour of Category 1 AMA Continuing Medical Education credit is offered for the reader's application for the Physician's Recognition Award of the American Medical Association.

Details and quiz on Page 785.

Sandoz Prize Article*

HEMORRHAGIC DIATHESSES:

Diagnosis and Management

AHMAD SAMI AHMADZAI, M.D.
Indianapolis

From the Lilly Laboratory for Clinical Research and Department of Medicine, Wishard Memorial Hospital, 960 Locke St., Indianapolis 46202. The author, formerly a Fellow in Hematology-Oncology, is now an assistant professor of medicine at Nangarhar School of Medicine, Jalalabad, Afghanistan.

*The monetary award presented to THE JOURNAL for having been selected recipient of first prize in the 1976 annual Sandoz Pharmaceuticals state medical journal competition is being used to fund publication of this article.

HEMORRHAGIC disorders represent a group of widely differing diseases characterized by an abnormal tendency to bleed. The action of platelets, the protein clotting mechanism, as well as the integrity of the vessel wall are all closely related in the prevention of bleeding. It is diagnostically convenient, however, to classify the abnormality as belonging to one of the following systems: vascular, platelet and blood coagulation (*Table 1*).

NORMAL HEMOSTASIS

The diagnosis and management of hemorrhagic diatheses requires an awareness of the normal hemostatic mechanism. Under physiologic conditions cessation of bleeding results from three processes: vessel



TABLE 1

Classification of Hemorrhagic Disorders

- I. Vascular Disorders
 1. Allergic purpura
 2. Hereditary Hemorrhagic Telangiectasia
 3. Autoerythrocyte and DNA Sensitivity
 4. Non-Allergic purpura
- II. Platelet Disorders
 1. Quantitative
 - a. Thrombocytopenia
 - b. Thrombocytosis
 2. Qualitative
 - a. Thrombasthenia
 - b. Thrombopathy
- III. Coagulation Disorders
 1. Congenital
 2. Acquired
- IV. Disorder Affecting Platelet Function, Blood Coagulation and Blood Vessels
(Von Willebrand's Disease)

constriction; formation of a platelet plug at the site of break in the vessel wall; and production of a fibrin clot. Once the primary hemostatic platelet plug has been formed, the process of coagulation using plasma factors is begun (*Figure 1*).

DIAGNOSIS

Accurate clinical diagnosis of the hemorrhagic diatheses depends on the demonstration of a specific defect. To attain this goal three questions must be answered: 1) Is the bleeding truly due to a hemorrhagic disorder, a local pathologic lesion or a combination of both? 2) If due to a hemorrhagic disorder, which of the three components of the hemostatic mechanism is affected? 3) What is the specific etiology of the bleeding? A medical history should be obtained and physical examination should be performed with these questions in mind.

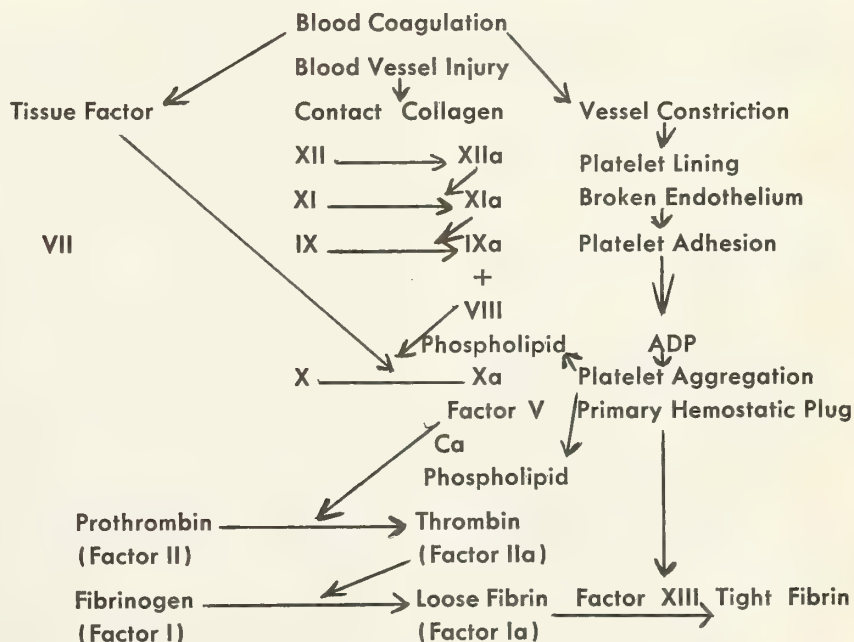
HISTORY

It is sometimes difficult to determine that a given patient has a hemorrhagic disorder. This question can often be answered by obtaining a good history, one that includes life-long events beginning with birth. A hemorrhagic disorder should be suspected when there is evidence of spontaneous bleeding into the skin, mucous membranes or interstitial tissue; if there has been simultaneous multifocal bleeding; or if there is a history of prolonged or excessive bleeding after surgery, either immediately after the wound or 24-48 hours later.⁸

In both children and adults, a careful history of previous or current medication must be obtained (aspirin, coumarin, persantin).

The family history is of paramount importance in determining whether the disorder is congenital or acquired. It is essential to discov-

FIGURE 1



er whether any members of the patient's family are known to have a bleeding disorder. Such a history should be looked upon with some degree of suspicion unless one can ascertain that proper laboratory confirmation was obtained to support the clinical diagnosis. A history of familial "bleeding" otherwise is suspect and needs accurate confirmation.

PHYSICAL EXAMINATION

Once the diagnosis of hemorrhagic diathesis is suspected, the examination should be directed in such a way that delineation of hemostatic mechanisms is focused upon as sharply as possible, then later supported by laboratory procedures.

VASCULAR DISORDERS

Vascular defects are among the most common causes of bleeding seen in clinical practice. These disorders are suggested by the finding of petechiae, ecchymoses and purpura. Characteristically, these lesions are located in the lower legs and ankles; however, they may appear anywhere. Allergic purpura (Henoch-Schonlein or anaphylactoid purpura) is an immune reaction involving small vessels. The purpuric lesions usually appear on the lower extremities and buttocks.⁷

In hereditary hemorrhagic telangiectasia, skin and mucous membrane lesions are round, pin point or up to about 3 mm in diameter, red, characteristically blanching on pressure and commonly located on the lips, tongue, ears, and nasal mucosa. They may be found in the gastrointestinal tract and can be the source of considerable bleeding.

Scurvy produces perifollicular hemorrhage, usually accompanied with bleeding of the gingiva. Bacterial rickettsial and viral infections cause petechial hemorrhage

TABLE 2 Platelet Disorders	
QUANTITATIVE PLATELET DISORDERS	
I. Thrombocytopenia	
A. Increased Destruction	
1. Due to Immunologic Process	
a. Autoantibodies (e.g. ITP)	
b. Isoantibodies	
c. Other immunologic processes	
2. Due to Nonimmunologic Processes	
a. Disseminated intravascular coagulation	
b. Microangiopathic disorders	
B. Decreased Production	
1. Marrow Displacement	
2. Ionizing Radiation or Myelosuppressive Drugs	
3. Vitamin B ₁₂ or Folic Acid Deficiency	
4. Inherited Lack of Thrombopoietin	
II. Thrombocytosis	
A. Myeloproliferative Disorders	
B. Neoplasm	
C. Connective Tissue Disorders	
QUALITATIVE PLATELET DISORDERS	
I. Thrombosthenia	
A. Impaired Platelet Function in Coagulation	
B. Impaired Platelet Function in Clot Retraction	
II. Thrombocytopathy	
A. Congenital	
B. Acquired	

widely scattered over the trunk as well as the extremities. The occurrence of purpuric lesions only, in the skin of the hands, feet and ears, suggests the presence of a cold agglutinin.

PLATELET DISORDERS

Platelet disorders are common and usually accompanied by superficial bleeding and petechiae. Bleeding from mucous membrane of the nose and from the uterus is frequent. Table 2 shows the classification of major causes of platelet disorders.

Idiopathic (autoimmune) thrombocytopenic purpura (ITP) is one of the most common of the throm-

bocytopenias. The diagnosis is contingent upon the exclusion of the secondary causes. ITP may be either acute or chronic. The acute form is most common before the age of 10 and two-thirds of these patients have a history of viral infection preceding the purpura by a few days to two-three weeks. Cerebral vascular bleeding occurs in less than 3% of such patients. Bone marrow examination is necessary to be sure megakaryocytes are present. In ITP they are increased in number and many are larger than normal. Ordinarily, splenomegaly is absent; if present, other causes for thrombocytopenia must be investigated.

Secondary thrombocytopenia from increased peripheral destruction is also common and may occur following ingestion of certain drugs.^{5,11} Some drugs can induce antibody formations, which in turn are able to attach to platelets and destroy them directly. Other medications are capable of directly destroying platelets without an immune mechanism. Still others act as haptens. This combination of a protein and drug acts as an antigen to which antibodies form; these attach to and destroy platelets.

Isoimmune thrombocytopenia can result from fetal-maternal platelet incompatibility. In the newborn infant with thrombocytopenia and purpura, one must also consider as causal cytomegalic inclusion disease, syphilis, herpes simplex and toxoplasmosis or associated disease in the mother (i.e., ITP or drug thrombocytopenia).

Thrombotic thrombocytopenic purpura (TTP) is a rare but usually fulminating disorder characterized by fever, hemolytic anemia, migratory neurologic signs and symptoms, and thrombocytopenia with progressive renal failure. The basic pathologic lesion is diffuse microthrombi.

Disseminated intravascular coagulation (DIC) may be manifest as an acute bleeding or purpuric disorder with sepsis, malignant disease, heat stroke, hypotension, etc. Thrombotic manifestations without bleeding, however, are a much more common presentation. Examination of the skin reveals petechiae, purpura, hemorrhagic bullae, acral cyanosis, gangrene, venipuncture bleeding and subcutaneous hemorrhage.⁴

Replacement or invasion of marrow by tumor, ionizing radiation marrow damage, vitamin B₁₂ and folic acid deficiency all cause throm-

bocytopenia by decreased platelet production. These can be recognized by their clinical characteristics and bone marrow examination.

Thrombasthenia (Glanzman's Disease) is an inherited malady which, in contrast to most functional platelet disorders, is often associated with severe bleeding even in non-surgical settings. Petechiae are common and spontaneous bruising may be marked.

Thrombocytopathy is made up of an amorphous group of platelet disorders comprising several different kinds of biochemical and metabolic defects. The most common type is acquired (uremia, myeloproliferative disorders, liver disease and aspirin). Although a decrease in plasma coagulation factors and thrombocytopenia also may occur, they are rarely sufficiently abnormal to account for the hemorrhagic tendency.

COAGULATION DISORDERS

A simplified illustration of the clotting process is shown in *Figure 1*.

The largest group of patients includes those with acquired deficiencies of several clotting factors (II, VII, IX, X), which result from treatment with coumarin drugs, vitamin K deficiency and liver disease.

A much smaller group of persons with coagulation disorders are those with one of the congenital clotting factor deficiencies. Of these 80 to 90% are classical hemophiliacs (low to absent levels factor VIII), about 10 to 20% have factor IX deficiency and only about 1% have decreased blood levels of one of the other factors.²

Patients with congenital clotting factor problems complain of excessive bleeding, either spontaneous or following trauma, starting early in life. They have a family history of a similar condition.

Hemophilia A (Factor VIII Deficiency)

This disorder results from a genetic defect of the X chromosome. Thus the disease is almost entirely confined to males although the female transmits it (sex-linked recessive). Hemophilia occurs in approximately 1 in 10,000 births. Its characteristic feature is the occurrence of bleeding at various sites, most often into muscles, the gastrointestinal and urinary tracts and into joints, where it results in deformity and loss of function. The severity of bleeding is related to the plasma level of the deficient factor; e.g., spontaneous bleeding rarely occurs in classical hemophilia until the plasma level of factor VIII decreases below 5% of the normal level.

Hemophilia B (Christmas Disease, Factor IX Deficiency)

This disease is also inherited as sex-linked recessive, and occurs in approximately 1 in 100,000 births. The sites of bleeding are identical to those seen in hemophilia A. Strangely enough, on the whole, the clinical disease is milder. Laboratory determination of clotting factors is necessary for its diagnosis.

Von Willebrand's Disease (Vascular Hemophilia)

This is a disease that occurs in about the same order of frequency as that of factor IX deficiency. The defect is not sex-linked and the etiology is not known. It is similar in clinical severity to mild hemophilia. Many, but not all, patients have a modest and often intermittent reduction in factor VIII concentration, which may be as low as 5-50% of normal. There is also a defect in platelets that fail to adhere to glass beads, but whether this parallels an inability to adhere to vessel wall defect is not known. Bleeding in joints rarely occurs, but

severe hemorrhage following surgical procedures is common. A prolonged bleeding time distinguishes this disease from hemophilia.

Deficiency of Other Clotting Factors

Single deficiencies of factors other than VIII and IX are extremely rare and will not be discussed in this review.

LABORATORY EXAMINATION

After completion of the clinical examination of the patient, the physician must obtain help from the laboratory to identify the particular defect responsible for the bleeding. The platelet count, bleeding time, clot retraction test, prothrombin time (PT) and activated partial thromboplastin time (APTT) should be obtained as screening tests (Table 3). Simple methods for determining vascular integrity are the Rumpel-Leedle phenomenon and the bleeding time.

In platelet disorders, thrombocytopenia (less than 50,000 platelets per cubic mm) is the most common cause of serious bleeding. It must be determined whether the thrombocytopenia is due to failure of platelet production or due to shortened platelet life span. Examination of smears from bone marrow aspiration are necessary. If megakaryocytes are few or absent, it may be assumed that platelet production is at fault, but if bone marrow megakaryocytes are numerous, the thrombocytopenia is usually due to excessive destruction or removal in the periphery.

There is no single test for the diagnosis of disseminated intravascular coagulation (DIC); however, four screening tests (PT, APTT, platelet count, and fibrinogen level) and three confirmatory tests (quantity of fibrin-degradation products, thrombin time and euglobulin lysis time) have clinical usefulness.¹¹

In qualitative platelet abnormalities (platelet dysfunction) bleeding time is increased and platelets usually are over 100,000 per cubic mm. Further characterization of acquired platelet dysfunction is seldom indicated.

The clotting process is initiated in the intrinsic and extrinsic pathways and leads to activation of the final common pathway in which the fibrin clot is formed (Figure 1). The simplest but least sensitive test for the integrity of the intrinsic and common pathway is the whole blood clotting time (Lee-White). It is prolonged in many but not all

hemophiliacs when the factor VIII level is about 1% of the normal level.⁹ It, therefore, is not useful as a presurgical "screen" for hemophilia. The activated partial thromboplastin time (APTT) is abnormal with factor VIII and factor IX levels of about 30%.

Prothrombin time (PT) reveals plasma clotting factor defects in the extrinsic and common pathways. Plasma fibrinogen level and thrombin time abnormalities detect defects in the common pathway. Once common pathway abnormalities have been localized by screening tests, the specific deficiency can be

TABLE 3
Initial Laboratory Test in Hemorrhagic Diathesis

Presumptive Diagnosis	Primary Screening Tests*				
	Bleeding Time	Platelet Count	Clot Retraction	APTT	PT
1. Vascular Disorders	±	N	N	N	N
2. Platelet Disorders					
A. Thrombocytopenia	↑	↓	A	N	N
B. Thrombocytosis	N or ↑	↑	N or A	N	N
C. Thromboasthenia	↑	N	A	N	N
D. Thrombopathy	↑	N	A	N	N
3. Coagulation Disorders					
A. Intrinsic Pathway (Deficiency of Factor XII, XI, IX, VII)	N	N	N	↑	N
B. Extrinsic Pathway (Deficiency of Factor VII)	N	N	N	N	↑
C. Common Pathway (Deficiency of Factor X, V, II, I)	N	N	N	↑	↑
4. Von Willebrand's Disease	↑	N	N	N or ↑	N

* N = normal; ↓ = decreased; ± = inconsistent; ↑ = increased; A = abnormal

identified by plasma clotting factor assays.

In Von Willebrand's disease, bleeding time is prolonged, platelet adhesiveness to glass beads is decreased and factor VIII plasma level is low.

MANAGEMENT

Vascular Disorders

These must often be treated symptomatically. Infiltration of vessel walls by abnormal proteins requires treatment of the underlying disease for correction of bleeding.

Platelet Disorders

In the quantitative platelet disorders, capillary hemorrhages in the brain, eyes, heart and kidneys are real risks. Therefore, trauma, forceful coughing and bending must be avoided. Stool softener may be prescribed to avoid straining at stool. Intramuscular injections and medications that interfere with platelet aggregation (aspirin) should be avoided. If a surgical procedure is undertaken, prior arrangements for platelet transfusion should be made.

The following points should be considered when prescribing platelet transfusions:

- Immune thrombocytopenic purpura, drug-induced purpura and DIC ordinarily do not respond to platelet transfusion due to marked peripheral destruction or utilization. However, platelet transfusion should not be withheld in these disorders in the face of a life threatening bleeding episode.

- Transfusion should be timed to coincide with greatest need; i.e., immediately before and after surgery and in thrombocytopenia due to leukemia, irradiation and cancer chemotherapeutic agents, when the platelet count is less than 10,000 to 20,000 per cubic mm.

- Adequate transfusion programs consist of at least one unit of

platelets per 7 kg of body weight (sufficient to raise the platelet number by 50,000). Platelet survival can be estimated by post-transfusion platelet counts (normal platelet circulation half-life = 5 days). If platelet survival is extremely short, repeated transfusions are not likely to be beneficial.

The primary therapy of ITP is corticosteroids and the value of corticosteroids in thrombocytopenia has been very clearly shown. The mechanism of action of steroids presumably is through suppression of antibody production, shortening of clotting time and stimulation of bone marrow.¹⁰ This hormone produces a complete remission in only 30% of adult ITP patients but is widely used as the initial therapeutic measure. Daily doses range from 20 to 60 mgs of prednisone by oral administration initially or a period of about two weeks. If a response is obtained, the dose should be tapered rapidly to the lowest dose giving a normal platelet count. If there is no response, steroids should be discontinued. When steroids fail to correct or ameliorate the disease, then splenectomy should be considered.

Splenectomy is the most effective treatment for the thrombocytopenia of hypersplenism. In ITP, splenectomy results in cure in at least two-thirds of patients and remains the ultimate therapeutic procedure. It is not indicated in the first attack of ITP in children since spontaneous recovery is the rule. Many chronic cases of ITP respond neither to steroid therapy nor to splenectomy. In this situation, however, immunosuppressive agents have shown some effectiveness.^{1,3}

When hemorrhage occurs in thrombasthenia, transfusions of normal isologous platelets may be advantageous; otherwise, treatment

is supportive.⁷ There is no specific therapy for thrombopathy.

When the platelet count is greater than 1 million per cu mm, thromboembolic complications or recurrent hemorrhage may occur. The platelet count may be lowered with removal by plasmaphoresis. This procedure should be continued until the platelet count has fallen well below 800,000 per cu mm. In less urgent situations, platelet count reduction can be obtained in 10 days with nitrogen mustard (10 mg/m² body surface area, I.V.). P³² and melphalan are also effective.⁶

Coagulation Disorders

Hereditary: These are treated by the replacement of blood or appropriate blood fractions to raise the level of the deficient factor to that necessary for hemostasis.

Whole blood transfusion, unless fresh, should be used to replace blood lost and should not be given to supply factor VIII because factor V and VIII each have a relative short half-life outside the body. Blood stored at 4° C loses a variable but definite amount of factor VIII over the course of several days. The dose and rapidity of administration depends on the patient's clinical condition.

Fresh or fresh frozen plasma are rich in clotting factors and remain the only preparations available for the treatment of factor V and XI deficiency. These preparations are seldom used in correcting factor VIII deficiency because, in the hemophiliac, plasma levels of factor VIII cannot usually exceed 10 to 20% before intravascular volume overload occurs. This level of factor VIII is not enough for control of open surface bleeding. The advantages of fresh frozen plasma are that it is simple to prepare, is readily available and carries less risk of hepatitis.

Availability of preparations of clotting factor concentrates has brought about profound change in the treatment of hemophilia. Two forms are available: blood bank cryoprecipitate and commercially prepared lyophilized products. Cryoprecipitate is obtained by slow thawing of quickly frozen fresh plasma. Because of its lower cost, volume and reduced risk for hepatitis it is still used by many in the treatment of factor VIII deficiency.

A number of lyophilized products are available. These stable materials are reconstituted with a few milliliters of saline or distilled water and can provide large quantities of factor VIII in a small volume.

In the replacement therapy of hemophilia with concentrates, one needs to know the approximate minimal level required to treat various kinds of bleeding, the amount of factor VIII in cryoprecipitate or other preparations, and the half-life of infused factor VIII.

Calculation of desirable factor VIII level is simple. It can be done in adults by estimation of plasma volume, which is 40 to 45 ml/kg body weight; one can then determine how many factor VIII units are necessary to achieve the desired level. Half-life of infused factor VIII is about 10 hours.

Precise measure of factor VIII plasma levels at four- to eight-hour intervals is necessary when major surgery is to be done for the classical hemophiliac. Non-operative bleeding episodes may be treated with doses of factor VIII at specific intervals based upon the activated partial thromboplastin time (APTT). Treatment of specific problems in hemophilia cannot be considered in this review, because each bleeding situation calls for a varied dosage, schedule, and duration of administration. Normal APTT just prior to a dose of factor

VIII is the ideal therapeutic goal.

Fresh or fresh frozen plasma is the treatment of choice in factor IX deficiency. A safe schedule consists of 15 to 20 ml/kg body weight at 12-hour intervals for a period of up to 14 days. With this therapy, levels of factor IX do not usually exceed 5 to 10% because of the large volume of distribution, but still this amount is usually adequate for control of enclosed soft tissue bleeding. Lyophilized protein fractions rich in factor IX have been shown to be clinically effective in the treatment of factor IX deficiency.

Von Willebrand's Disease: The treatment of this disease may be initiated with one container of cryoprecipitate or with infusion of 10 to 15 ml of plasma/kg of body weight. Therapeutic effect may be determined by measuring bleeding times. For reasons currently not fully understood, a given quantity of factor VIII given to a patient with Von Willebrand's disease is followed by a much more prolonged increase in plasma level of this factor than would be found in a patient with Classical Hemophilia. Therefore, treatment at 24- to 48-hour intervals may be sufficient in the Von Willebrand's disease patient. With surgery, however, treatment is usually necessary every 12 hours. Lyophilized factor VIII concentrates are not effective.

Surgery in any of the above "hemophilia syndromes" requires therapy until primary wound healing occurs.

Acquired: Rapid restoration of clotting factor activity can be achieved with plasma (fresh or fresh frozen) starting with 15 to 20 mg/kg of body weight followed by one-third the dose at 8- to 12-hour intervals. By use of Vitamin K (50 mg), restoration of a normal prothrombin time may be expected

within 6 to 18 hours if the liver is capable of synthesizing the "K-dependent" coagulation factors.

SUMMARY

The purpose of this review is to briefly outline the normal clotting mechanism and methods of diagnosis and treatment of the more common bleeding disorders. An accurate history is essential. Accurate laboratory tests done on the basis of the history confirm the diagnosis. Availability of component blood products for use in some of the congenital clotting factor defects and their proper application has been discussed, as well as the treatment of common platelet disorders.

REFERENCES

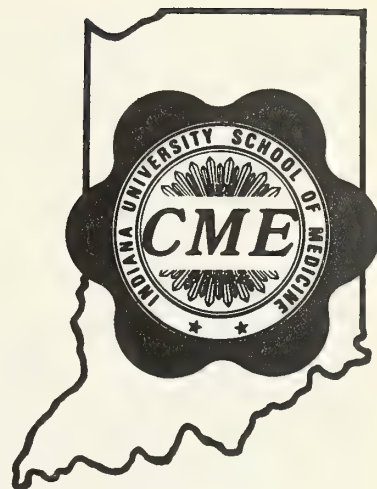
1. Ahn, YS, Harrington, WJ, *et al.*: Vincristine therapy of idiopathic and secondary thrombocytopenias. *New Eng. J. Med.* 291:376, 1974.
2. Biggs, R, MacFarlane, RG: Hemophilia and related conditions: A survey of 187 cases. *Brit. J. Hemat.* 4:1, 1958.
3. Bouroncle, BA, Doan, CA: Treatment of refractory idiopathic thrombocytopenic purpura. *JAMA* 207: 2049, 1969.
4. Colman, WR, Robboy, JS, *et al.*: Disseminated intravascular coagulation. *Amer. J. Med.* 52:679, 1974.
5. Crosby, HW: Wet purpura, dry purpura. *JAMA* 232:744, 1975.
6. Lewis, SM, Scur, L: Myeloproliferative disorders, *Brit. Med. J.* 4:399, 1974.
7. Nemerson, Y: Diagnosis of hemorrhagic disorders, *Med. Clinic. North America* 57:531, 1973.
8. Schwartz, O: The clinical manifestations of bleeding. *Med. Clinic North America* 56:17, 1972.
9. Strauss, SH: Diagnosis and treatment of hemophilia. A practical guide, pp. 22-49, 3rd Ed., Albany Medical College, Albany, New York, 1972.
10. Sussman, N: Understanding the coagulation system and managing hemostatic defects. *Modern Med. J.* pp. 88, Oct. 16, 1972.
11. Williams, JW: Textbook of hematology. pp. 1120-1235, McGraw-Hill, Philadelphia, Pennsylvania, 1972.

THE JOURNAL, in cooperation with the Division of Postgraduate and Continuing Medical Education of the Indiana University School of Medicine, offers its readers a Continuing Medical Education program. This is the eighth in a series of articles written for purposes of continuing medical education—produced by the faculty of the School of Medicine and supported by a grant

from its Division of Postgraduate and Continuing Medical Education.

Through reading and following each article carefully and answering the Quiz correctly, one hour of Category 1 AMA Continuing Medical Education credit is offered for the reader's application for the Physician's Recognition Award of the American Medical Association.

Details and quiz on Page 793.



Current Concepts in the Management of Pulmonary Tuberculosis

RICHARD ZIEGLER, M.D.
STEPHEN J. JAY, M.D.
RICHARD E. BRASHEAR, M.D.
Indianapolis

ABSTRACT

Although the incidence of tuberculosis has decreased dramatically in recent years, the disease continues to be a significant public health problem and a source of patient suffering. Over 500 new cases of tuberculosis are reported annually in Indiana. The recent development of highly effective anti-tuberculosis agents and new programs for their administration, including intermittent and short-course regimens, have provided physicians with increased flexibility in the management of this disease. Responsibility for the treatment of patients with tuberculosis has shifted from sanatoria to community hospitals and private physicians. This has created new problems in coordinating tuberculosis control activities with the Public Health Department. By utilizing new concepts of drug therapy and coordinated out-patient management, more than 95% of patients with tuberculosis will be cured of their disease. Further reduction in the incidence of tuberculosis will require a well-organized and co-operative effort of physicians, volunteer health agencies and public health personnel.

From the Pulmonary Division of the Department of Internal Medicine, Indiana University School of Medicine, Indianapolis.

Acknowledgment: Dr. Ziegler is supported by the Sunnyside Guild of Marion County, Ind.

Requests for reprints should be addressed to Stephen J. Jay, M.D., Indiana University Medical Center, Regenstrief Bldg., 1001 W. 10th St., Indianapolis 46202.

ALTHOUGH tuberculosis was once a leading cause of morbidity and mortality in this country, both the incidence of new cases and of deaths due to this disease have decreased markedly in recent years. Between 1956 and 1976, the decrease in the number of new cases, case rates and death rates in the United States was paralleled by similar changes in Indiana (Table 1).^{1,2}

Despite these trends, tuberculosis remains a significant problem in this country, as well as in other technically advanced countries such as Great Britain where approximately 8,000 new cases of tuberculosis were reported in 1974. In underdeveloped nations the problem is much greater. It has been estimated that 15 to 20 million people with active tuberculosis live in these countries where case rates may be as high as 300 new cases of active tuberculosis per 100,000 population per year.³

The introduction of effective chemotherapy for tuberculosis has been the most important factor in decreasing morbidity and mortality

of this disease, and has resulted in changes in the management of patients with tuberculosis.⁴ Many of these changes have occurred over the past few years and therefore may be unfamiliar to practicing physicians. Since the responsibility for treatment of patients with tuberculosis is shifting from the tuberculosis hospital to practicing physicians, it is important to consider recent developments in the management of this disease.

The infectiousness of patients following initiation of drug therapy, criteria for hospitalization and discharge, outpatient management and new concepts of chemotherapy will be reviewed. This discussion will be limited to a consideration of patients with tuberculosis infection with clinical disease (Category III of the recently revised classification of tuberculosis, Table 2).⁵ The management of drug resistant tuberculosis will not be considered.

INFECTIOUSNESS OF TUBERCULOSIS

Tuberculosis is transmitted by minute particles containing *Mycobacterium tuberculosis* organisms

(droplet nuclei) that arise from the respiratory tract during forceful expiratory maneuvers such as coughing and sneezing. Because of their small size, these droplet nuclei may disseminate widely, remain airborne for hours, and if inhaled they may be distributed to distal airways and alveoli during respiration.⁶ The probability of a person inhaling a droplet nucleus and acquiring tuberculosis infection is related primarily to the density of these particles in the inspired air and the duration of exposure. The density of droplet nuclei, in turn, is dependent upon patient, drug and environmental factors.

Patient factors include the bacteriologic status of the patient, the type and frequency of forceful expiratory maneuvers, and the location and nature of the tuberculous respiratory tract lesion. Patients who have tubercle bacilli present on sputum smear and in culture, and who are actively coughing, are more infectious than patients who have minimal cough and few organisms in expectorated sputum. The presence of cavitory infiltrates on chest roentgenogram correlates well with both the numbers of acid fast bacilli seen on sputum smear and infectiousness.⁷

Chemotherapy is the single most important factor in decreasing the infectiousness of tuberculosis. Following initiation of chemotherapy, the risk of a patient infecting contacts decreases rapidly, even in patients with positive sputum smears.^{6,8,9} The risk to contacts of a patient with active pulmonary tuberculosis is greatest prior to diagnosis and initiation of therapy. The exact time that a patient becomes non-infectious after starting chemotherapy is impossible to determine and varies with individuals. However, if the patient's clinical condi-

TABLE 1: CHANGE IN TUBERCULOSIS DISEASE & DEATH RATES FROM 1956 TO 1976^{1,2}

	UNITED STATES		INDIANA	
	1956	1976	1956	1976
New Cases	69,895	32,549	1,479	515
New Case Rate†	41.6	15.0	33.4	10.3
Death Rate†	8.4	1.3	7.3	0.9

† Number per 100,000 population per year.

TABLE 2: REVISED CLASSIFICATION OF TUBERCULOSIS*

CATEGORY O: Not exposed, not infected

Data: No significant exposure, Mantoux test (5 TU PPD-S)† negative (0-4 mm).

Plan: No further evaluation or treatment.

CATEGORY I: Tuberculosis exposure, no evidence of infection

Data: History suggests definite possibility of transmission; initial tuberculin test negative.

Plan: Follow Guidelines for the Investigation and Management of Tuberculosis Contacts, Official Statement of American Thoracic Society, May 1976. (Amer Rev Resp Dis, 1976, 114, 459).

CATEGORY II: Tuberculosis Infection without Disease

Data: History of significant risk of transmission; tuberculin skin test reaction ≥ 5 mm induration; no clinical, radiographic or laboratory evidence of disease.

Plan: Follow Guidelines for Preventive Therapy of Tuberculosis Infection, official statement of American Thoracic Society, (Am Rev Resp Dis, 1974, 110,371).

CATEGORY III: Tuberculosis Infection with Disease

Data: Clinical radiographic, and/or laboratory evidence of tuberculosis.

Plan: See text.

* Adapted from: Diagnostic Standards (of Tuberculosis), a Monograph of the American Lung Association, 1974.

† 5 tuberculin units of purified protein derivative-standard.

tion is improving, and if the frequency of cough and the number of acid fast bacilli on sputum smear are decreasing, isolation may be discontinued after approximately two to three weeks of chemotherapy.^{8,10} The period of isolation should be extended to four to six weeks if there are infants or children in the household.

During isolation, exposure to new contacts should be minimized. The patient should be instructed in mouth coverage during coughing and sneezing, and tissues from the patient should be disposed of by burning or flushing down the toilet. The use of masks to prevent airborne transmission of tuberculosis remains a controversial issue. Current guidelines of the Center for Disease Control recommend that masks should be worn by visitors during the period of isolation.^{10,11} However, some experts suggest that

with effective ventilation and ultraviolet lights, the use of masks by the visitor and/or patient is not necessary.¹² For the mask to be effective, it must be properly worn and must be capable of filtering airborne droplet nuclei 1-5 μ m in size; such masks are currently available for general use.¹³

Circulation of the air in a patient's room is another determinant of the density of droplet nuclei. Air should be vented from patient rooms directly to the outside without being recirculated to other areas of the hospital. The ventilation system should change the air in the room at least six times per hour. However, ventilation alone is not an efficient method of disinfection since to achieve significant reduction in the number of droplet nuclei would require a ventilation system which is noisy, costly and drafty. The proper placement, maintenance,

and use of ultraviolet lighting will reduce the number of droplet nuclei to a degree equivalent to approximately 50 room air exchanges per hour.¹⁴⁻¹⁶

HOSPITAL ADMISSION AND DISCHARGE

Until the past decade the care of patients with tuberculosis was confined primarily to the tuberculosis hospital or sanatorium where the average length of stay was long and where treatment programs stressed bedrest, nutritious diet, and fresh air. In 1952 there were 93,000 patients hospitalized with tuberculosis in the United States and the average length of hospitalization was 299 days.¹⁷ The introduction of effective chemotherapy, increased knowledge concerning infectiousness of patients receiving chemotherapy, and the lack of evidence that prolonged sanatorium care benefited patients¹⁸ have resulted in a marked decrease in the number of patients hospitalized with tuberculosis (5,500 in 1974) and the duration of hospitalization (85-90 days in 1974).¹ Since the majority of tuberculosis sanatoriums have been closed, patients who require hospitalization are usually admitted to community hospitals.

The decision to hospitalize a patient with tuberculosis must be individualized. Hospitalization is indicated when the patient is clinically ill, when specialized tests or procedures are indicated to establish a diagnosis and when effective isolation cannot be achieved at home.¹⁹ During the hospitalization a tuberculosis education program for the patient and family can be initiated. The patient can be closely monitored for adverse reactions to tuberculosis drugs. Discharge from the hospital may follow discontinuation of isolation if the patient is

TABLE 3: COMPARISON OF THE MANAGEMENT OF TUBERCULOSIS IN THE 1950's AND 1970's

MANAGEMENT	1950's	1970's	FUTURE
Hospitalization	Sanatorium (months to years)	None or community hospital (weeks to months)	None or community hospital (weeks to months)
Duration of chemotherapy	2 yrs to "life"	6-18 mo	6 mo or less
Number of doses	1500-3000	190-550	50-100
Surgery	Common	Uncommon	Rare
Monthly chest radiograph, sputum smears and cultures	Standard practice	Selected patients	Selected patients
Initial and follow-up sensitivity tests in all patients	Standard practice	Selected patients	Selected patients
Follow-up after completion of chemotherapy	Years to life	None to 1 year	None to <1 year
Responsibility for follow-up	Sanatorium/Public Health Dept.	Private physician/community hospitals/Public Health Dept.	Private physician/community hospitals/Public Health Dept.

tolerating chemotherapy, has been adequately educated, and if careful arrangements for outpatient management have been made. In some patients long-term institutionalization is necessary. These individuals can be effectively and safely cared for in community hospitals that have established tuberculosis programs or in institutions designed for the care of the chronically ill.^{20,21} In patients who do not have an indication for hospitalization, evaluation, education and initiation of therapy may be carried out in an outpatient setting.

Following hospital discharge, and providing further isolation is not necessary, the patient should be encouraged to return to normal activities when physically able. The decision to return to work should be individualized. In general, if the patient feels well, is tolerating drug therapy and has objective evidence of response to treatment (significant reduction in number of tubercle bacilli in sputum), return to work may be recommended. Pa-

tients who work with children, i.e., teachers, school bus drivers, medical and para-medical personnel, etc., or with persons who are immunologically impaired, should wait a longer time before returning to work.²²

OUTPATIENT MANAGEMENT

With the change in emphasis from long-term inpatient management to outpatient management, ambulatory care facilities and follow-up programs have become very important to the successful management of patients with tuberculosis. The outpatient program must ensure that a patient remains on effective chemotherapy and must provide the necessary chest roentgenographic and mycobacteriologic support to document the efficacy of therapy. Clinic personnel must monitor the patients for symptoms and signs of drug toxicity and must provide continuing education for the patient and family. Because as many as one-third of patients with tuberculosis are alcoholics,²³ the

program must be designed to cope with recalcitrant and unreliable patients. This requires close cooperation with public health personnel who can assist in locating and providing drugs to patients who have failed clinic appointments.

In recent years, the outpatient evaluation and management of patients with tuberculosis have changed (*Table 3*). In the past, patients were followed with frequent, regularly scheduled chest roentgenograms, and sputum smears and cultures. When chemotherapy was completed, re-evaluation was carried out at frequent intervals for many years. Many patients who were successfully treated for tuberculosis were followed indefinitely. Patients today are followed at regular intervals while receiving chemotherapy with emphasis on education, documentation of drug ingestion and sputum conversion, and early recognition of drug toxicity.

Sputum smears for acid-fast bacilli should be performed month-

ly for the first three to four months of chemotherapy. During this time, monthly sputum cultures are not necessary since approximately 15 to 25% of patients on effective therapy will remain culture positive after three months.³ Since more than 90% of patients become culture negative by the fifth to sixth month of therapy, sputum smears and cultures should be obtained at this time and repeated monthly until sputum conversion has occurred (i.e., two to three consecutive negative sputum cultures). When sputum conversion occurs, there is no reason to obtain further cultures unless dictated by clinical and/or roentgenographic changes.²⁴ If the sputum culture does not convert to negative within six months, careful reassessment of the therapeutic program is required with particular attention to patient compliance.

Chest roentgenograms should be obtained monthly for the first three to four months and then at the completion of therapy unless the patient's clinical status deteriorates. Following completion of therapy, chest roentgenograms need not be performed routinely.²⁴

Although routine initial drug sensitivity studies may be indicated in areas where the incidence of primary drug resistance is high, serial sensitivity studies on positive cultures in all patients is not recommended. Drug sensitivity testing is indicated in a drug regimen that is failing and in patients who have relapse of tuberculosis.³

After successfully completing a course of antituberculous therapy, the patient may be considered cured and needs to be followed for no more than six to twelve months since those who relapse usually do so within the first three to six months following completion of therapy.^{3,25}

There are some patients who

should be followed for a longer time after completion of drug therapy.²⁴ Included in this group are those whose course was complicated by development of resistant organisms, and patients who are suspected of having taken antituberculous agents sporadically because of unreliability or drug toxicity. In addition, patients with extensive residual pulmonary parenchymal changes of tuberculosis and co-existing disease associated with malnutrition or immunosuppression should be examined at regular intervals since the incidence of relapse in these patients may be increased.

CHEMOTHERAPY

Completion of an adequate course of chemotherapy is the most important factor in the successful treatment of pulmonary tuberculosis. In recent years, new drugs, notably rifampin and ethambutol, have been developed and are highly effective and relatively non-toxic. These drugs have largely replaced para-aminosalicylic acid (PAS) and to some extent streptomycin in the initial therapy of tuberculosis.

Anti-tuberculous drugs may be categorized as "first line" and "second line" drugs (*Table 4*).²⁶ First line drugs are used in the initial treatment of tuberculosis. They are highly effective, reasonably inexpensive and have minimal toxicity. Second line drugs are used in the treatment of patients who have drug resistant tuberculosis. These agents are less effective and much more toxic than first line drugs. In general, the use of second line drugs should be limited to centers where personnel are experienced in their use.

The successful treatment of tuberculosis requires the administration of two or more antituberculous drugs. The importance of using at least two agents may be appreciated by reviewing the effect of ther-

apy on the emergence of drug resistant mycobacteria. Multiple drugs are used to minimize the possibility of the emergence of drug resistant tuberculosis in patients with initially susceptible organisms.

Approximately one in 10^5 naturally occurring *Mycobacterium tuberculosis* (M.tb) organisms are resistant to isoniazid and approximately one in 10^6 organisms are resistant to streptomycin. The chance of naturally occurring bacilli being resistant to both isoniazid and streptomycin is the product of these probabilities, or one in 10^{11} . When large numbers of organisms are present as in the case of cavitary pulmonary tuberculosis where there may be in excess of one in 10^9 mycobacteria, the chances of mycobacteria developing resistance to a single drug are great; use of two or more antituberculous agents markedly decreases the likelihood that the organisms will develop resistance.¹⁸ When relatively few viable mycobacteria exist (fewer than 10^4) as in the case of a patient who becomes infected without evidence of clinical tuberculous disease (Category II), a single drug, isoniazid, may be used with little risk of development of drug resistant organisms.²⁷

A variety of drug regimens may be used for the treatment of pulmonary tuberculosis (*Table 5*). The selection of chemotherapeutic agents depends upon the extent of disease initially present. With extensive cavitary disease and large numbers of M.tb organisms, three anti-tuberculous drugs are indicated during the initial one to three months of chemotherapy to enhance rapid sputum conversion.¹⁸ Following this initial intensive phase of therapy, a continuation phase consisting of two anti-tuberculous drugs (isoniazid and ethambutol) should be administered daily for an additional

TABLE 4: TREATMENT OF MYCOBACTERIAL DISEASE IN ADULTS AND CHILDREN*

First-Line Drugs	Dosage**		Most Common Side Effects**	Tests For Side Effects**	Remarks**
	Daily	Twice Weekly			
Isoniazid	5-10 mg/kg up to 300 mg PO or IM	15 mg/kg PO or IM	Peripheral neuritis, hepatitis, hypersensitivity	SGOT/SGPT (not as a routine)	Bactericidal. Pyridoxine 10 mg as prophylaxis for neuritis; 50-100 mg as treatment
Ethambutol	15-25 mg/kg PO	50 mg/kg PO	Optic neuritis (reversible with discontinuation of drug; very rare at 15 mg/kg), skin rash	Red-green color discrimination and visual acuity†	Use with caution with renal disease or when eye testing is not feasible
Rifampin	10-20 mg/kg up to 600 mg PO	Not recommended	Hepatitis, febrile reaction, purpura (rare)	SGOT/SGPT (not as a routine)	Bactericidal. Orange urine color. Negates effect of birth control pills
Streptomycin	15-20 mg/kg up to 1 g IM	25-30 mg/kg	8th nerve damage, nephrotoxicity	Vestibular function, audiograms;† BUN and creatinine	Use with caution in older patients or those with renal disease
Second-Line Drugs					
Viomycin	15-30 mg/kg up to 1 g IM		Auditory toxicity, nephrotoxicity, vestibular toxicity (rare)	Vestibular function, audiograms;† BUN and creatinine	Use with caution in older patients; Rarely used with renal disease
Capreomycin	15-30 mg/kg up to 1 g IM		8th nerve damage, nephrotoxicity	Vestibular function, audiograms;† BUN and creatinine	Use with caution in older patients; Rarely used with renal disease
Kanamycin	15-30 mg/kg up to 1 g IM		Auditory toxicity, nephrotoxicity, vestibular toxicity (rare)	Vestibular function, audiograms;† BUN and creatinine	Use with caution in older patients; Rarely used with renal disease
Ethionamide	15-30 mg/kg up to 1 g PO		GI disturbance, hepatotoxicity, hypersensitivity	SGOT/SGPT	Divided dose may help GI side effects
Pyrazinamide	15-30 mg/kg up to 2 g PO		Hyperuricemia, hepatotoxicity	Uric acid, SGOT/SGPT	Combination with an aminoglycoside is bactericidal
Para-aminosalicylic acid (aminosalicylic acid)	150 mg/kg up to 12 g PO		GI disturbance, hypersensitivity, hepatotoxicity, sodium load	SGOT/SGPT	GI side effects very frequent making cooperation difficult
Cycloserine	10-20 mg/kg up to 1 g PO		Psychosis, personality changes, convulsions, rash	Psychologic testing	Very difficult drug to use. Side effects may be blocked by pyridoxine, antirheumatic agents or anticonvulsant drugs

* Treatment of Mycobacterial Disease, an official statement of the American Thoracic Society, adopted October 16, 1976, Am Rev Resp Dis, 115:185, 1977. Reprinted with permission of the American Thoracic Society.

** Check product labelling for detailed information on dose, contraindications, drug interaction, adverse reactions, and monitoring.

† Initial levels should be determined on start of treatment.

TABLE 5: RECOMMENDED DRUG REGIMENS FOR PULMONARY TUBERCULOSIS

REGIMEN	EXTENT OF DISEASE*	INITIAL TREATMENT**	CONTINUATION PHASE
STANDARD-DAILY	Non-Cavitary	INH EMB	Daily for —————→ a total of 18 mo.
	Cavitary	INH EMB RIF or SM	Daily for 1-3 months INH } Daily for an additional 15-17 mo. EMB }
STANDARD-INTERMITTENT	Non-Cavitary	INH EMB or SM	Twice per week for —————→ a total of 18 mo.
	Cavitary	INH EMB RIF or SM	Daily for 1-3 months INH } Twice per week 15-17mo. EMB } for an additional
SHORT COURSE-DAILY	Non-Cavitary	INH RIF	Daily for —————→ a total of 9-12 mo.
	Cavitary	INH RIF EMB or SM	Daily for 2 months INH } Daily for an additional 7-10 mo. RIF }

* See text for further definition

** INH = isoniazid; EMB = ethambutol; RIF = rifampicin; SM = streptomycin

15 to 17 months. Noncavitary tuberculosis can be successfully treated with isoniazid and ethambutol administered daily for 18 months. Successful completion of standard daily regimens outlined in *Table 5* produces excellent results with minimal toxicity. The relapse rate during five years following completion of therapy is less than 4%.^{24,28,29}

There are several problems associated with prolonged daily anti-tuberculosis drug regimens. It is difficult for patients to take drugs for sustained periods of time, especially when they are asymptomatic or when they are experiencing drug toxicity.^{30,31} Discontinuation of standard chemotherapeutic regimens has been associated with relapse rates of 62% if medication is discontinued at six months, and 14%

if medication is discontinued at 12 months.²⁸ The recent development of intermittent and short course drug therapy (*Table 5*) has improved patient acceptance of antituberculous treatment and the cost of treatment is considerably less than when standard regimens are used.

In intermittent chemotherapy programs, the patient usually takes the drugs twice weekly under the supervision of medical or paramedical personnel. This program is particularly suited to the unreliable patient who cannot be relied upon to ingest drugs regularly. Intermittent drug treatment is effective and is associated with minimal toxicity.^{32,33} The disadvantages include a relatively high cost for clinic facilities and personnel, and patient inconvenience incurred by two to three

clinic visits per week. The latter problem may be avoided by administration of drugs twice weekly by visiting nurses in the patient's home. In patients with cavitary disease, an initial daily three-drug regimen of one to three months is followed by twice weekly drug administration for an additional 15 to 17 months. With non-cavitary disease, isoniazid and streptomycin or isoniazid and ethambutol are given twice weekly for 18 months (*Table 5*).³³

Short-course chemotherapeutic regimens, requiring drug ingestion for only six to 12 months have recently been investigated in several large trials in other countries.^{34,35} These regimens are highly effective, result in lower cost of treatment, less drug toxicity, and excellent pa-

tient compliance. The British Thoracic and Tuberculosis Association currently recommends a nine-month course of daily isoniazid and rifampin supplemented by ethambutol (25 mg/kg) for the first two months of therapy during the initial treatment of pulmonary tuberculosis.³⁵ Evidence indicates that the two-drug regimen of isoniazid and rifampin is probably as effective as the three-drug regimen containing ethambutol.^{3,34}

An exciting aspect of these newer drug regimens is that using a combined intermittent short-course protocol, total drug dosage may be decreased to approximately 50 to 75 total doses.^{3,36,37} Preliminary results indicate that the cure rate and relapse rate with these drug regimens are excellent.

REFERENCES

1. Tuberculosis in the United States, U.S. Department of Health, Education, and Welfare, Public Health Service, DHEW Publication No. (CDC) 76-8322, p. 4, August 1976.
2. Tuberculosis in the United States, 1977, Morbidity and Mortality Weekly Report, DHEW Publication No. (CDC) 78-8017, 27:63, 1978.
3. Fox, W: The modern management and therapy of pulmonary tuberculosis, *Proc Roy Col Phys*, 70:4, 1977.
4. Johnson, RF, Wildrick, KH: "State of the Art". The impact of chemotherapy on the care of patients with tuberculosis, *Am Rev Resp Dis*, 109:636, 1974.
5. Diagnostic standards and classification of tuberculosis and other mycobacterial diseases, American Lung Association, American Thoracic Society, New York, 1974.
6. Riley, RL, Mills, CC, O'Grady, F, et al: Infectiousness of air from a tuberculosis ward, *Am Rev Resp Dis*, 85:511, 1962.
7. Lundon, RG, Spohn, SK: Cough frequency and infectivity in patients with tuberculosis, *Am Rev Resp Dis*, 99:109, 1969.
8. Riley, RL, Moodie, AS: Infectivity of patients with pulmonary tuberculosis in inner city homes, *Am Rev Resp Dis*, 110:810, 1974.
9. Gunnels, JJ, Bates, JH, Swindoll, H: Infectivity of sputum-positive tuberculosis patients on chemotherapy, *Am Rev Resp Dis*, 109:323, 1974.
10. Isolation techniques for use in hospitals, 2nd Ed., U.S. Department of Health, Education, and Welfare, Public Health Service, DHEW Publication No. (CDC) 76-8314, p. 42, 1975.
11. Guidelines for prevention of tuberculosis transmission in hospitals, U.S. Department of Health, Education and Welfare, Public Health Service, DHEW Publication No. 00-2545, p. 7, 1975.
12. Stead, W: Personal communication, May 10, 1978.
13. Guyton, HG, Decker, HM: Respiratory protection provided by five new contagion masks, *Appl Microbiol*, 11:66, 1963.
14. Riley, RL: Airborne infection, *Am J Med*, 57:466, 1974.
15. Guidelines for prevention of tuberculosis transmission in hospitals, U.S. Department of Health, Education and Welfare, Public Health Service, DHEW Publication No. 00-2545, p. 4, 1975.
16. Riley, RL: Principles of UV air disinfection, U.S. Department of Health Education and Welfare, Public Health Service, 1972.
17. Tuberculosis Programs 1972, U.S. Department of Health, Education, and Welfare, Public Health Service, DHEW Publication No. (CDC) 74-8189, p 1, Nov 1973.
18. Fox, W: The John Barnwell Lecture: Changing concepts in the chemotherapy of tuberculosis, *Am Rev Resp Dis*, 97:767, 1968.
19. American Thoracic Society, Standards for tuberculosis treatment in the 1970's, *Am Rev Resp Dis*, 102:992, 1970.
20. American Thoracic Society, Guidelines for the general hospital in the admission and care of tuberculosis patients, *Am Rev Resp Dis*, 99:631, 1969.
21. American Thoracic Society, Guidelines for long-term institutional care of tuberculosis patients, *Am Rev Resp Dis*, 113:253, 1976.
22. American Thoracic Society, Guidelines for work for patients with tuberculosis, *Am Rev Resp Dis*, 108:160, 1973.
23. Lowell, AM, Edwards, LB, Palmer, CE: Tuberculosis. American Public Health Association, Vital and Health Statistics Monographs, Harvard University Press, Cambridge, Massachusetts, p. 26, 1969.
24. Albert, RK, Iseman, M, Sbarbaro, JA, et al.: Monitoring patients with tuberculosis for failure during and after treatment, *Am Rev Resp Dis*, 114:1051, 1976.
25. American Thoracic Society, Discharge of tuberculosis patients from medical surveillance, *Am Rev Resp Dis*, 113:709, 1976.
26. American Thoracic Society, Treatment of mycobacterial disease, *Am Rev Resp Dis*, 115:185, 1977.
27. American Thoracic Society, Preventive therapy of tuberculous infection, *Am Rev Resp Dis*, 110:371, 1974.
28. British Medical Research Council: Long-term chemotherapy in the treatment of chronic pulmonary tuberculosis with cavitation, *Tubercule*, 43: 201, 1962.
29. Pearce, SJ, Horne, NW: Follow-up of patients with pulmonary tuberculosis adequately treated by chemotherapy: Is this really necessary? *Lancet*, 2:641, 1974.
30. Moulding, T, et al.: Supervision of outpatient drug therapy with the medication monitor, *Ann Int Med*, 73:559, 1970.
31. Fox, W: General considerations in the choice and management of regimens of chemotherapy for pulmonary tuberculosis, *Bull Int Un Tuberc*, 47:49, 1972.
32. Fox, W: General considerations in intermittent drug therapy of pulmonary tuberculosis, *Postgrad Med J*, 47:729, 1971.
33. American Thoracic Society, Intermittent chemotherapy for adults with tuberculosis, *Am Rev Resp Dis*, 1974, 110:374, 1974.
34. Fox, W, Mitchison, DA: Short-course chemotherapy for pulmonary tuberculosis, *Am Rev Resp Dis*, 111: 325, 845, 1975.
35. British Thoracic and Tuberculosis Association. Short-course chemotherapy in pulmonary tuberculosis, *Lancet*, 1:1102, 1976.
36. Singapore Tuberculosis Service/British Medical Research Council: Controlled trial of intermittent regimens of rifampin plus isoniazid for pulmonary tuberculosis in Singapore, *Lancet*, 2:1105, 1975.
37. Stead, W: Second Annual Sunnyside Guild Lecture, Indiana University School of Medicine, March 15, 1978.

A Study in Longevity

ABSTRACT

Having medical offices in five different west-central Indiana communities has offered my associates and me a unique opportunity to observe differences in longevity in one of these towns. A study of nonagenarians in this community—Russellville, Ind.—provides some interesting socio-economic and epidemiological clues to the development of atherosclerosis. The study may also provide clues to the pathogenesis of cancer since the overall incidence of cancer increases with age—and the people studied had no significant tumors. We obtained specific facts from these nonagenarians regarding age, sex, weight, activity, diet, dissipation, genetic and stress factors. The results showed they maintained a normal weight and blood pressure all their life. They had a low level of stress. They ate any food they desired, but caloric intake did not exceed caloric expenditure. They did not smoke or drink, and they all had long-lived relatives.

J. FRANKLIN SWAIM, M.D.
Rockville

RUSSELLVILLE, Ind. is an isolated rural village in the northwest corner of Putnam County with a population of about 300. It has no industry. The people who live there and in the surrounding area are either farmers, retired farmers, or people who manage farm related businesses. Most of them have lived there all their lives. There are very few new arrivals and few people who commute out of town to work. The town has no tavern, but it does have two churches.

Russellville came to my attention because of the preponderance of old people in the community, especially for its size. The other towns that I regularly visit—and where I see many more patients—are Rockville, population 3,000; Clinton, 7,000; Cayuga, 1,200, and Kingman, pop-

From the Parke Clinic, 503 Anderson St., Rockville, Ind. 47872.

ulation 300. Although some of these towns are much larger than Russellville, in none of them did I see so many nonagenarians. It made me think these people might be an isolated group of Caucasians similar to what has been described of the people in the Soviet Union who inhabit the Caucasus Mountains.

Even more fascinating to me were the dietary implications, for I, having been reared on a farm in a family that had been farmers for generations on both sides, knew their diet was full of cholesterol, hog fat, and as much sugar and salt as they wanted. This point fascinated me more than their age, for they ate in liberal amounts what we physicians have been taught, and what we instruct our patients, not to eat.

Ever since starting medical school I, like all other physicians, have been caught up in the verbal and printed blitz of research reports, articles, lectures, and books extolling the merits of an almost endless array of diets that advise the deletion of cholesterol, lipids, salt, sugar and at various times all other foodstuffs. This study of the aged people in Russellville indicates the American diet is the best in the world. The problem is that there is too much of it.

SUBJECTS AND METHODS

We interviewed 10 of these people, eight who were in their 90's and two who would be 90 in a few months. This is a small number with which to reach any conclusions. However, this is a town of only 300. In none of the other larger towns do I have this many patients of this age. I believe this sample of 10 provides a representative background to obtain facts from which we may draw our conclusions regarding dietary, stress,

genetic and socio-economic factors that are conducive to longevity, or that have no influence on longevity regardless of current scientific and popular opinion. Furthermore, this is all we could easily find in the community.

I formulated a questionnaire to obtain specific facts regarding age, sex, weight, activity, diet, dissipation (smoking and drinking), genetic factors of longevity, and tried to evaluate stress factors by examining their stability of life as evidenced by their having lived all or most of their life in the community, and also by their stability of occupation. My office nurse did all the interviewing, since she had always lived in the community and knew all the people. Not all of the people interrogated were our patients. Our only criteria for selection was that they were 90 and used Russellville as their trade center.

RESULTS

When I told my office nurse of the study I was interested in doing, her remark was, "Well, the first thing you'll find out is that they're all thin."

This was the first, and I think the most vital fact. We had four men and six women in the group. The women ranged from 85 to 142 pounds, with an average of 113 pounds. They ranged from 5 feet to 5 feet 3 inches, with an average of 5 feet 1½ inches. The men ranged from 125 pounds to 140 pounds, with an average of 138 pounds. They ranged from 5 feet 8 inches to 6 feet, with an average of 5 feet 9½ inches. Only one of the women could be considered overweight, and most of the others were downright skinny. Furthermore, they had been the same weight all of their life, plus or minus 10 pounds, except one who weighed 179 pounds before he married 70 years ago, af-

ter which he quickly dropped to his present 132 pounds.

All except one of the group had diastolic pressures below 90. Her blood pressure was 200/100, and she has been taking medicine for hypertension for many years. In spite of this, she is 92. She, like most of the others in the group, lives alone and takes care of herself. None of these people are nursing home-type patients. They are all up and around, many driving their own cars and working in their own gardens. A few of them don't even go to a doctor, and my nurse had to catch them buzzing up and down the street in order to interview them.

Besides being normotensive and underweight as a group, they had all engaged in daily physical activity all of their life, which was necessary since they were all farmers or farm wives. One was a teacher, but he too worked regularly on a farm. However, there were no joggers in the group, and none who purposefully exercised every day so they could live longer. Having grown up on a farm, I know that none of these farmers ever engaged in the violent physical exercise that joggers do. Almost every day there was something to do of a mildly strenuous nature like shoveling grain, digging postholes, cutting wood, or chasing livestock. The most stressful physical exercise any of the women did was hoe and work in the garden, and percentage-wise, more of them are nonagenarians than men. (Maybe the men exercised too much.)

Neither the men nor the women did anything to the point of exhaustion. Their's was a gentle, but regular exercise. There was none who exercised with the vehemence of the physical cultists of today who lash their protégés onward toward ever greater distances and speeds, then

watch incredulously as some of them drop dead in their tracks while still in their 40's when they are out running their self-imposed gauntlet. It is interesting how these people remain undaunted, and keep racing ever onward. They should heed these old farmers and exercise daily in moderation, and stop trying to make marathon runners out of middle aged and old aged people.

The next factor investigated in the study of the elderly people of Russellville was their diet, and to me this is the most interesting aspect of the study. Their diet has always been high in cholesterol and animal fats, for they had all the eggs, bacon, gravy, and hog fat they wanted. Everything was fried in lard. They had all the desserts, jellies, jams, and salt they wanted. There were no self-imposed dietary restrictions placed on any of these people interviewed, and they all admitted eating the foods I just mentioned. They ate heartily. Of course, it was a balanced diet, and they had all the fresh fruits and vegetables they wanted. Obviously the dietary key to their longevity is *not what they ate, but how much they ate relative to their total caloric needs*. Their caloric intake did not exceed their caloric expenditure, and therefore they maintained a normal body weight all their life.

These people did not dissipate themselves. None of the 10 ever drank. Only one smoked all his life, and he quit four years ago because of a "coughing fit." This correlates well with other research reports that show a direct relationship between smoking and a shortened life span.

There was a positive genetic factor in all these people. They all had relatives who were in their late 80's or 90's. This has also been proven by other research reports and is as expected.

The last element investigated was the stress factor. This is difficult to evaluate, but I believe they were never subjected to the stress that a lot of people experience because all those interviewed have lived in the Russellville area all of their life. They did not have the stress of moving from job to job or of trying to compete for an ever higher position in a business, academic or professional hierarchy. Knowing the work habits of farmers, I know they had a very regular schedule all through life which certainly reduces their stress. They got up at 5:30 a.m. every day of their life and went to bed at 9:30 p.m. every night. When daylight savings time came several years ago, they left their clocks and watches as they were, and let the rest of the world move their watches up and go its stressful, nerve-wracking, dissipating way. They are all calm, affable, easy-going individuals who accept life as they find it, are not constantly dissatisfied, and are relatively happy with themselves, their work, and the world they live in.

There have been studies that correlate certain neoplasms with certain personality types, which in turn are classified according to a person's reaction to stress. None of these people observed had any obvious neoplasms, except one with a skin cancer. This study would give further credence to the theory that there is an association between stress and the development of neoplasms. Even obesity, hypertension and dissipation place a stress factor upon various organ systems of the body. Of course, there is also an obvious genetic factor involved in the development of several different neoplasms, and it is quite difficult to ascertain the relative importance of genetics versus stress in the development of neoplasms, which ultimately seems to cause all death.

I once read that we all died of either atherosclerosis or cancer. With the latest evidence indicating that atherosclerosis is now probably a neoplastic process, we can say that we all essentially die of cancer. Cancer, aging and death are relatively synonymous terms. When we know what causes us to grow old, then we shall know what causes cancer. (As a corollary to that, we shall never be able to prevent, or cure aging, so we shall never be able to prevent, or cure cancer. We are obviously able to modify its course, but we don't cure it. We may win a medical battle, but we inevitably lose the war.) This study at Russellville indicates that genetic and stress factors are inexorably intertwined together to accelerate or retard the aging (cancerous) process.

COMMENTS

In summary, if one has as his goal the attainment of nonagenarian or centenarian status, this study would indicate the following elements are important:

- Maintain a normal weight and blood pressure.
- Exercise daily, in moderation. Jogging and strenuous activities are not necessary.
- Try to keep stress as low as possible. While we can't all be farmers in Russellville, perhaps we can approach our work and problems with the equanimity and regularity that a farmer approaches his occupation.
- One may eat any food he desires, but the total caloric intake must not exceed the total caloric expenditure.
- Smoke and drink as little as possible. Don't dissipate yourself.
- Investigate the genetic factors of longevity in your family, and don't expect to live longer than the average age at death of your relatives.

Poison Ivy (Rhus) Dermatitis

JERE D. GUIN, M.D.
Kokomo

THE subject of poison ivy dermatitis is steeped in folklore, myths and homespun remedies. In spite of a considerable amount of investigative data, it seems to be poorly understood by a large segment of the population. The eruptions caused by poison ivy (*Rhus radicans*), poison oak (*Rhus toxicodendron*) and poison sumac (*Rhus vernix*) are not distinguishable by their appearance or severity.^{1,2} Therefore, the term *Rhus* dermatitis is often used for any of these.

Rhus dermatitis is by far the most common and dramatic form of allergic contact dermatitis.³ Most normal individuals will show positive patch tests by two-three weeks

after adequate first exposure to poison ivy.³ Following this, they ordinarily react to challenge within 24-48 hours. Extreme limits of six hours to 11 days have been reported with shorter reaction time for more sensitive people or more concentrated antigen.²

The route and dosage of the first exposure(s) seem to determine how allergic the individual ultimately becomes. For instance, sensitization by oral contact or by mild cutaneous exposure may actually offer a degree of protection by inducing only a mild degree of allergy.^{2,4} Once the level of sensitivity is established, it tends to remain somewhat constant for a time and then slowly diminishes with age.

The villain in poison ivy dermatitis is an oleoresin contained in the leaf, stem and root of the plant.^{2,5} Its activity is caused by four pentadecyl catechols that differ in their degree of unsaturation. The oleoresin is contained within the leaf, which must be broken before a reaction can occur. Leaves are antigenic throughout the growing season, but become less potent after they dry out and fall off the plant.²

The oleoresin is not carried by the wind, (it is not found in pollen⁶) but particles in smoke may be a problem for extremely sensitive persons.⁷ Oleoresin carried on inanimate objects may deteriorate in a week in a highly humid summer

environment,² but it can persist for years when kept very dry.¹ Left on the skin, it loses much of its activity after 24 hours and can't be found after the third day.² Contrary to popular myth, there is no antigen in blister fluid.^{2,6} Since one would not expect to find the oleoresin on the skin by the third day, patients at the height of the eruption should not transmit the condition to other people. However, antigen can be transferred from contaminated hands for about six hours.¹

Many patients deny exposure to poison ivy as if it were a disgrace. However, a motivated patient occasionally proves to be Sherlockian. I remember one individual who repeatedly developed poison ivy dermatitis on the posterior thighs and could not find any obvious source of exposure. It turned out that her dog was attracted to a particular couch where she often sat clad only in her underwear (dogs can carry the oleoresin on their fur without breaking out). When the dog was removed from the premises, the formerly recalcitrant eruption was no longer a problem.

Prevention of *Rhus* dermatitis is largely a matter of recognizing the plant and avoiding exposure. Once exposed, highly sensitive individuals achieve some benefit by washing the skin immediately (up to five minutes) after contact while mildly sensitive persons will benefit up to 30

The author, a frequent contributor to THE JOURNAL, is a diplomate of the American Board of Dermatology and is a clinical assistant professor of dermatology at the Indiana University School of Medicine.



Poison Ivy

minutes.² Barrier creams have been advocated in the past, but they simply don't work.² Hyposensitization is usually limited to individuals who are highly allergic and who, by nature of their work and activities, are frequently exposed. The best method available seems to be that originally described

by Shelmire almost 40 years ago.*⁸ Hyposensitization should never be carried out during the acute phase of the eruption or soon thereafter. It is usually started after the first frost, provided the patient has not recent-

*This can be obtained through Hollister-Stier Laboratories.

ly had active lesions.

Treatment of the active phase is largely limited to systemic corticosteroid therapy provided there are no contraindications. In the past, topical therapy has been said to be ineffective, and, therefore, not appropriate. However, more potent topical corticosteroids recently have been shown to have some effect even without occlusion.⁹ In my practice, persons unable to take oral corticosteroids can usually be satisfactorily managed with topical corticosteroid and occlusion. Two 24-hour periods are required, separated by one day of rest. This procedure should be withheld until antigen is no longer present on the skin (three or more days after exposure).

BIBLIOGRAPHY

1. Shelmire, Bedford: The poison ivy plant and its oleoresin. *J Invest Dermatol* 4:337-348, 1941.
2. Kligman, Albert M: Poison ivy (Rhus) dermatitis. An experimental study. *Arch Dermatol* 77:149-180, Feb. 1958.
3. Fisher, Alexander A: Contact Dermatitis, ed 2. Philadelphia, Lea & Febiger, 1973, pp 1-6, 260-266, 1973.
4. Lowney, Edmund D: Dermatologic implications of immunological unresponsiveness. *J Invest Dermatol* 54(5): 355-364, May 1970.
5. Shelmire, Bedford: Nature of the excitant of poison ivy dermatitis. *Arch Dermatol and Syph* 42:405-409, Sept. 1940.
6. Shelmire, Bedford: Contact dermatitis from weeds: Patch testing with their oleoresins. *JAMA* 113(12): 1085-1090, Sept. 16, 1939.
7. Crooks, Donald M and Klingman, Dayton L: Poison ivy, poison oak and poison sumac. *Farmers' Bulletin* No. 1972, U.S. Government Printing Office, U.S. Department of Agriculture, Washington, D.C. Revised Jan. 1971.
8. Shelmire, Bedford: Hyposensitization to poison ivy. *Arch Dermatol and Syph* 44(6): 983-998, Dec. 1941.
9. Kaidbey, Kays H and Kligman, Albert M: Assay of topical corticosteroids. Efficacy of suppression of experimental Rhus dermatitis in humans. *Arch Dermatol* 112:808-810, June 1976.

Survival Rates of Major Abdominal Vascular Injury in an Eight-Year Period

PETER B. YAW, M.D.
MICHAEL ZAHM, M.D.
JOHN L. GLOVER, M.D.
Indianapolis

MILLIONS of dollars are being spent nationwide on general improvements in Emergency Medical Services (EMS),⁵ and studies strongly suggest that on-scene and pre-hospital treatment of myocardial infarction patients by advanced methods decreases the mortality rate significantly, in part by controlling arrhythmia.¹⁻⁴ Since similar benefit to traumatized patients has not been demonstrated, we reviewed our experience with major abdominal vascular trauma during an eight-

year period when EMS markedly improved in our community.

During the latter years of this study, the provision of advanced EMS became a reality in our community and greatly improved medical management of the acutely ill or injured patient over conventional modalities in several aspects. Insertion of large bore intravenous channels (saphenous or antecubital venotomy or venapuncture), chest tube thoracostomy, endotracheal tube intubation and cardiac defibril-

From the Department of Surgery, Wishard Memorial Hospital, Indiana University Medical Center, Indianapolis 46202.

lation have become standard practice at the scene when indicated. In addition, two-way communication and EKG telemetry between the scene and the emergency room physician has allowed for effective cardio-pulmonary resuscitation and cardioversion.

The most important advancement, however, has been the improved training of emergency personnel and decreasing response time so that these medical advances are utilized quickly and correctly for the benefit of the sick or traumatized patient.

CLINICAL MATERIAL

Between 1968 and 1976, 24 patients with major abdominal vascular trauma were treated at Wishard Memorial Hospital. This study is specific for aortic and inferior vena caval injuries below the diaphragm, including the common iliac vessels. Most of the injuries were gun shot wounds, with knifings and blunt abdominal trauma accounting for only a few.

TABLE 1 Number of Associated Organs Injuries	
# of Visceral Injuries	# of Patients
1	0
2	6
3	4
4	7
5	7

All patients in this study were taken to the operating room; all but two were male, with the average age being 31 years and ranging from 17 to 62. Aortic injury accounted for four of the cases, inferior vena caval injuries totaled 15, and the number of combined injuries was five. In all cases, two or more visceral injuries occurred in addition to the vascular injuries (Tables 1 and 2).

Blood pressure on admission to the emergency room was less than

60 mm Hg. systolic in 12 patients (no survivors), between 60 and 100 mm Hg. systolic in four patients (one survivor), and above 100 mm Hg. systolic in eight patients (six survivors). In the emergency room, large intravenous portals were secured, roentenographic studies were performed if indicated, and patients were typed and cross-matched for multiple units of whole blood. Autotransfused blood was also available in the emergency room and the operating room.

As a rule, abdominal exploration in the operating room began less than one hour after arrival in the Emergency Room. Blood pressures taken upon arrival in the operating room were less than 60 mm Hg. systolic in five patients (no survivors), between 60 and 100 mm Hg. systolic in four patients (no survivors), and greater than 100 mm Hg. in 12 patients (seven survivors) (Table 3). A standard midline incision was employed and early aortic cross-clamping was used in half of the cases. Upon entry into the peritoneal cavity, free bleeding was encountered in all of the operative deaths, while only one of the seven survivors had free bleeding upon initial entry. Operative blood transfused averaged 7,000 cc. (including autotransfusion), and the primary modality of repair was ligation or direct suture of the vessel(s) involved.

TABLE 2 Associated Organs Injured	
Liver	9
Small Bowel	9
Duodenum	7
Colon	6
Pancreas	4
Stomach	4
Spleen	3
Diaphragm	3
Renal Artery	2
Superior Mesenteric Artery	2
Kidney	2
Superior Mesenteric Vein	2
Portal Vein	2
Renal Vein	1
Common Bile Duct	1
Lung	1

RESULTS

Of the 24 patients, there were 11 operative deaths, two immediately postoperative deaths, and three deaths within 24 hours after surgery. One patient died on hemodialysis three weeks post-injury. The overall survival rate was 29% in our series. Complications were frequent in the surviving patients, but not unexpected in view of the severity of the injury (Table 4).

Operative mortality was a function of preoperative and intraoperative hypotension, extensive associated injury, and exsanguination. All survivors had a preoperative blood pressure of greater than 100 mm Hg. systolic, and all but one had no active bleeding upon abdominal exploration. Six of the seven survivors

TABLE 3 Arrival B/P - mm Hg. Systolic		
	Number	Survivors
0-60	12	0
60-100	4	1
>100	8	6
Pre-Op B/P - mm Hg. Systolic		
	Number	Survivors
0-60	5	0
60-100	4	0
>100	12	7
Unknown	3	0

had venous injury with no arterial component, and direct suture or ligation was the means of repair (Table 5). Almost half of the survivors sustained their injury prior to effective establishment of advanced EMS; and the survivals occurred at random times in the entire study period, indicating no correlation between increased survival and improvement in emergency medical services (Table 6).

TABLE 4 Complications of Survivors	
Dehiscence	2
Thrombophlebitis	3
Hematuria	2
ETOH withdrawal	1
DIC	1
Pneumothorax	1
Cardiac Arrest	1
Sepsis	1
ATN	1
Allergic Drug Reaction	1
Wound Infection	1
None	1

COMMENTS

Review of the literature shows that penetrating injuries to the abdominal aorta have a mortality rate of 50-70% and those to the inferior vena cava, a rate of 50-55%.⁸⁻¹³ In our series, abdominal aortic injuries had a mortality rate of 75% and inferior vena caval injuries 60%. Combined arterial-venous injury carried a mortality rate of 100%, and the overall mortality rate was 71% (Table 5).

Factors that might influence the results of this study include:

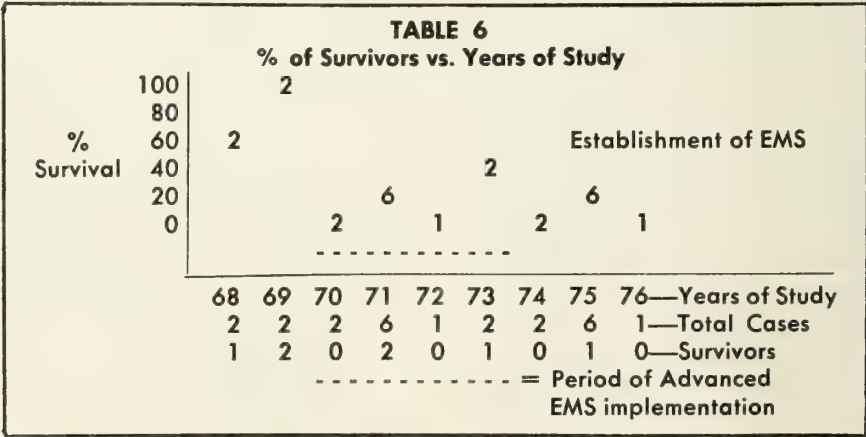
- Changes in the kinds of patients;
- Changes in the community itself such as kinds of weapons, numbers of injuries, and different patterns of referral;
- Changes in the pre-hospital management; and
- Changes in the management after the patients reached the hospital.

TABLE 5 Types of Vascular Injury					
	Number	%	Survivors	% of Total	Mortality Rate
Arterial	4	16.6	1	4%	75%
Venous	15	62.6	6	25%	60%
Combined	5	20.8	0	0%	100%
Totals	24	100%	7	29%	71%

Regarding the first factor, we found no changes either in the individual or demographic patterns of the patients reviewed. Changes in "community factors" are not apparent from examination of the coroner's records, with the possible exception of adoption of the .357 magnum as the standard weapon for police in 1975. It wounded no patients in this series, however. Furthermore, although there was a slight increase in coroners' autopsies for gunshot wounds between 1968 and 1976, there was no significant change in numbers of injuries to the abdominal aorta and vena cava. In addition, the referral pattern for these patients has remained constant since law requires that patients under arrest—and unconscious, unattended patients—come to our hospital (which is also in the area where most of these injuries occurred.)

Examination of the role of pre-hospital treatment is difficult because of the small number of patients involved and the sporadic implementation of various improve-

ments in the system of care. Furthermore, the lack of adequate records in the early years of the study precluded accurate comparison of even such simple statistics as response time for the ambulances and time from injury to operation. Because of the geographic locations of the injuries and the existence of a good hospital-based ambulance service throughout the entire period of study, however, we know that response times were good initially and are excellent at present. We also know that the patients seen before 1972 had virtually no pre-hospital care and that the later ones received only that treatment which could be given in the short ride to the hospital and which sometimes included intubation and administration of balanced salt solutions, since instructions to our emergency personnel include rapid transport of these patients and minimal time spent at the scene. Consequently, one might expect a decreased survival rate in the latter years of the study because of patients arriving at the hospital alive who would have



been dead on admission in the earlier years. Although this does not appear to be the case, the small number of cases and their sporadic occurrence make manipulations of these numbers relatively unimportant.

Most of the factors in the hospital care of these patients remained constant throughout the study: excellent emergency and operating facilities staffed with experienced personnel 24 hours a day; ample type-specific blood available in five minutes; a "chief" surgical resident and experienced assistants including an anesthesiologist on duty in the hospital. In 1971, intraoperative autotransfusion became available; and full-time faculty replaced clinical faculty members in assisting the resident staff on these cases when possible. We were not able to correlate either of these changes with variations in the courses of the patients with this injury.

In fact, the only things that were correlated with survival were preoperative systolic blood pressure above 100 mm Hg. and hemorrhage that was contained by surrounding tissues when surgery began. These two factors obviously seem to be correlated with each other and must be intrinsically related to the patients and to their responses to the

wounds. We think it is unlikely that pre-hospital manipulations would affect such factors positively and therefore urge those caring for such patients to have them brought to the hospital without delay. In areas where paramedics treat mainly cardiac patients, this message may need emphasis.

Our purpose, however, is not to oppose improvements in emergency medical services, but to make a plea for more assessments of the value of the various aspects of these complicated and expensive systems before legislating them for all communities. We are confident, for example, that citizens in our community have received very significant benefits from the improvements made in emergency care; but we are unable to measure those improvements by determining the outcome for patients injured as severely as these. Additional studies of different types of patients are needed before we can make meaningful statements about the appropriate kinds of systems for different types of communities.

REFERENCES

1. Adgey, A, *et al*: Acute phase of myocardial infarction. *Minn. Med.* 59:347, 1976.
2. Crampton, RS, *et al*: Reduction of pre-hospital, ambulance, and community coronary death rates by the

community-wide emergency cardiac care system. *Am. J. Med.* 58:151, 1975.

3. Campton, RS, *et al*: Pre-hospital coronary care in Charlottesville and Albermarle County. *Virg. Med. Monthly* 99:1191, 1972.
4. Zilberman, D: Resuscitation of patients with ischaemic heart disease before admission to the hospital. *Resuscitation* 4:1, 1975.
5. Presentation to EMS administrators national meeting on July 20, 1976 in Carson City, Nevada by John Reardon, deputy director, EMS/DHEW.
6. Hardy, JD, *et al*: Aortic and other arterial injuries. *Ann Surg.* 181: 640-653, 1975.
7. Miller, JM, *et al*: Gunshot wound of the inferior vena cava. *Am. Surg.* 41:175-176, 1975.
8. Lim, RC Jr, *et al*: Acute abdominal aortic injury: an analysis of operative and postoperative management. *Arch. Surg.* 109:706-711, 1974.
9. Buchness, MP, *et al*: Gunshot wounds of the suprarenal abdominal aorta. *Am. Surg.* 42:1-7, 1976.
10. Mattox, KL, *et al*: Management of acute combined injuries to the aorta and inferior vena cava. *Am. J. Surg.* 130:720-724, 1975.
11. Cheek, RC, *et al*: Diagnosis and management of major vascular injuries: a review of 200 operative cases. *Am. Surg.* 41:755-760, 1975.
12. Mattox, KL, *et al*: Management of penetrating injuries of the suprarenal aorta. *J. Trauma* 15:808-815, 1975.
13. Yeo, MT, *et al*: Penetrating injuries of the abdominal aorta. *Arch. Surg.* 108:839-842, 1974.



McClain Car Leasing, Inc.

1745 Brown St., Anderson, Ind.

Phone 317/642-0261

Specializing in Professional Car Leasing

ALL MAKES AND MODELS AVAILABLE

We are proud to offer a Leasing Plan approved by ISMA

Radiation-Associated Thyroid Cancer

CORBIN P. ROUDEBUSH, M.D.
Indianapolis
GEORGE T. ASTERIS, M.D.
East Chicago

THE possibility of a link between thyroid cancer and previous radiation to the head and neck was first suggested in 1950. In recent years, it has been proven that such therapy leads to an increased occurrence of a variety of benign and malignant tumors in the area of radiation. Of these tumors, thyroid cancer has been best studied.

Thymic, tonsillar and adenoidal enlargement, cervical adenopathy, hemangiomas and a variety of dermatologic conditions, including acne, account for perhaps 95% of indications for radiotherapy. Although exact figures are not available, it is estimated that two million Americans are at risk for thyroid cancer subsequent to radiation.

Prospective studies from recent screening programs throughout the country show detectable thyroid abnormalities in approximately 30% of radiated individuals. It appears that 5% to 10% of all radiated patients will eventually develop histologically proven thyroid

cancer. The relationship between radiation dose and thyroid tumorigenesis has been reviewed by several groups of investigators. The incidence of neoplasia increases linearly up to a thyroid dose of approximately 1,000 to 1,500 rads, but may decrease with higher doses. As little as seven rads has been suggested to be causal in the series of 11,000 persons exposed to very low doses of therapeutic radiation. Mean thyroïdal doses in most series, however, are in the order of several hundred rads.

The latent period between exposure and diagnosis is approximately 20 years, and it is unknown whether the incidence ultimately returns to that of normal populations. Some authors have suggested that after 30 to 35 years the incidence is the same for non-radiated populations. In our experience, however, approximately 10% of tumors develop after 30 years, and some have occurred as late as 50 years. Whether such tumors are radiation-

From the Departments of Medicine of St. Catherine's Hospital, East Chicago, Ind., and Methodist and St. Vincent Hospitals, Indianapolis.

Address reprint requests to Dr. Roudebush, Suite 203, 2020 W. 86th St., Indianapolis 46260.

associated or spontaneous remains a matter of speculation. It had been believed that children were more sensitive to radiation, but significant carcinogenesis has been demonstrated through early adulthood.

EXPERIMENTAL THYROID CANCER

Factors operative in causing thyroid tumors in experimental animals have been characterized as initiators and promoters. Initiators are believed to induce an irreversible effect, most likely by altering genetic structure. Promoters are factors possessing a transient and reversible effect stimulating tumor growth.

External radiation and perhaps the administration of radioiodide are felt to be initiator factors in the development of thyroid cancer. Thyrotropin (TSH) is thought to be the most frequent physiological promoter. Thyroid hormone replacement, through suppression of TSH, results in a diminution in experimentally induced thyroid neoplasia, presumably by suppressing this promoter. It has been shown in the rat that high doses of radioiodide, perhaps analogous to those used therapeutically for Graves' disease, lead to a lower incidence of subsequent thyroid cancer than do lower doses. Larger doses presumably result in cell death or arrest of replication. Smaller doses appear to induce genetic changes and other effects on cell metabolism leading to carcinogenesis.

PATHOLOGY

A satisfactory nomenclature for the pathology of thyroid carcinomas has been developed by the World Health Organization. Using their nomenclature, it appears that papillary and follicular carcinomas occur with increased frequency after radiation. It is unlikely that anaplastic, squamous cell or medullary carcinomas occur at any increased

frequency in radiated patients. Approximately 30 cases of parathyroid adenoma have been reported in irradiated subjects, and it is felt that the two are causally related and that many more cases will eventually be reported. Other tumors found with increased frequency in association with radiation have been of the salivary glands, skin, breast and brain. Although irradiation seems to be a major cause of thyroid cancer in young adults, the histologic types of those malignancies do not differ from that in non-irradiated populations, when patients are controlled for age.

The natural history of radiation-associated cancers as studied to date appears to be similar to that of spontaneously occurring thyroid cancer, and both have a good prognosis when adequately treated surgically and with radioiodide. Recently there has been much discussion in medical literature regarding the so-called "occult" thyroid carcinoma. Although no universal definition has as yet been accepted, the term refers to tumors found at post-mortem examination or incidentally at surgery. Some confusion has arisen from attempts to relate the biological potential of these tumors to size criteria. We reviewed a group of 110 patients with thyroid cancer and these tumors were not more common in irradiated subjects.

NATURAL HISTORY OF THYROID CANCER

Papillary thyroid cancer forms about 90% of the tumors seen in irradiated patients, and several factors have been delineated that appear to have an influence on its prognosis. Death as a specific consequence of this cancer is unusual in patients diagnosed under age 40, but recurrence of the tumor during therapy appears to be fairly common. Invasion of local neck

structures or distant metastases are, of course, correlated with a poor prognosis. There appears to be a direct correlation between the size of primary lesions and the rate of recurrence and death. There is very low mortality in patients with lesions less than 1.5 cm in diameter. Although patients who have more extensive surgical procedures have a somewhat better prognosis, complications are less frequent with lesser procedures. Major complications include permanent hypoparathyroidism, permanent vocal chord paralysis, brachial plexus and facial nerve injury. These have been reported to occur in more than a third of patients treated with total thyroidectomy and radical neck dissection. They may be reduced by using great care during lymph node dissection. Radical neck dissection may influence the rate of recurrence, but does not appear to have an effect on overall prognosis. Post-surgical suppression with thyroid hormone using 150 to 300 micrograms of l-thyroxine or its equivalent has a favorable influence on prognosis. In our experience follicular carcinomas in younger patients, although they represent only about 10% of irradiated patients, also have an excellent prognosis. Absence of significant invasion and distant metastases (in follicular tumors) are also correlated with good prognosis.

Cases of anaplastic and medullary carcinomas after radiation have been reported, but there is no evidence to suggest that these occur at a higher rate than expected by chance. We recently reviewed 110 patients with radiation-associated thyroid cancer. They were compared to age and pathology-matched controls, extensively screened for the absence of history of radiation. The only statistically significant variable between the two groups was the presence of multi-

centric thyroid primaries in the x-ray exposed group. Irradiated subjects, however, tended to have more advanced disease, with local invasion or distant metastases at the time of diagnosis. A higher rate of recurrence was observed in the irradiated population, even though they were treated more aggressively. Thyroid cancer specific death rate was essentially identical in both populations.

DIAGNOSIS, TREATMENT

Several studies have suggested that repeated examinations of the thyroid by several persons is the single most useful screening procedure in irradiated patients. Surgery is recommended for those patients in whom one or more nodules are found, regardless of the results of scintiscanning. The type of surgery recommended is contingent on the availability of an experienced thyroid surgeon. An experienced surgeon may perform near total thyroidectomy (NTT), a procedure intended to remove all evident thyroid tissue except that which would compromise the parathyroid glands or recurrent laryngeal nerves when these structures are unaffected by tumor, with a rate of significant complications of less than 5%.

Modified radical neck dissection, sparing nervous structures and the sternocleidomastoid muscles, is the procedure of choice when obvious neck nodal metastases are present. However, as stated previously, this procedure per se has little effect on prognosis and is probably not indicated prophylactically.

In subjects with normal thyroid glands on physical examination, thyroid scan with ^{123}I or $^{99\text{m}}\text{Tc}$ is performed. These isotopes have significant advantages over ^{131}I primarily in causing less thyroid and total body exposure to radiation. A pin-hole collimator defines small lesions much better than rectilinear scan-

ning. If a definite, localized area of decreased uptake is observed, surgery is recommended. The type of operation is dependent upon the findings at surgery. When benign disease is present, lobectomy is the surgical procedure of choice. When malignancy is found, near total thyroidectomy and post-operative ablation of any remaining thyroid tissue is indicated. If the scan is normal, the patient is given thyroid hormone replacement and followed at yearly intervals with physical examinations by an experienced thyroid examiner. If at anytime the thyroid reveals clear nodularity, surgery is recommended.

Patients with thyroid abnormalities, other than discrete nodularity, fit into a third group. Abnormalities under this category include:

- A firm diffusely irregular surface;
- Diffuse enlargement, greater than two times normal;
- Definite increase in firmness in an otherwise normal thyroid;
- An uncertain group, meaning that several observers have felt the neck and no general agreement exists.

All of these patients have a radioisotope scan. Surgery is recommended when a definite, localized area of decreased uptake is demonstrated. If the scan is normal, the patient is given thyroid hormone replacement and followed at six monthly intervals initially and yearly after three unchanged examinations. Surgery is recommended if a localized abnormality becomes evident at any follow-up interval. If the scan shows inhomogeneous distribution of the radioisotope, circulating thyroid autoantibodies (both thyroglobulin and microsomal antibodies) are determined.

In the presence of positive thyroglobulin or thyroid microsomal antibodies, the patient is seen again

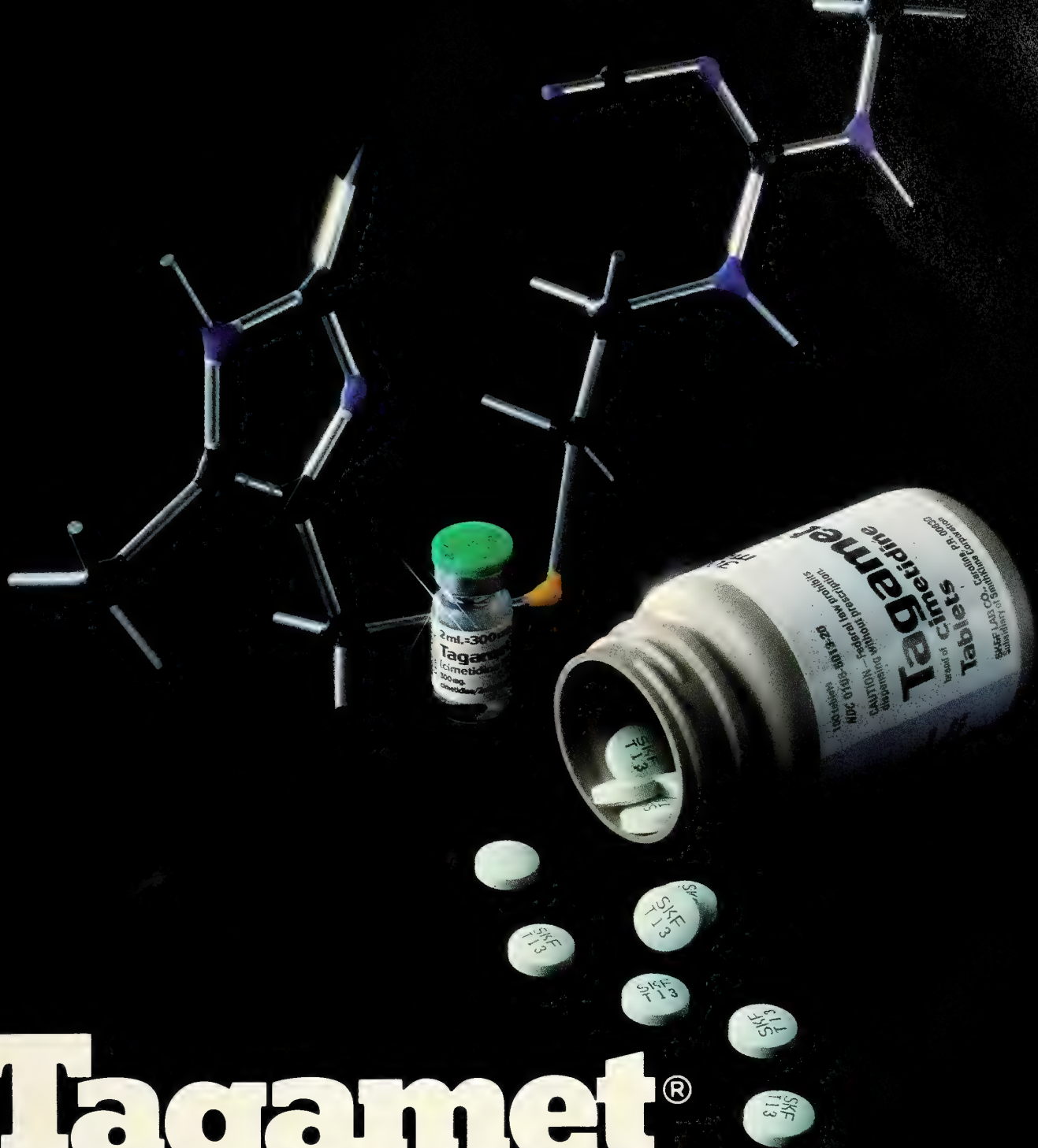
in six months and then at yearly intervals. If antibodies are negative and an abnormality is present which lends itself to percutaneous biopsy, this procedure is performed. If the biopsy shows changes compatible with malignancy, surgery is recommended. If the biopsy is not technically possible, unsuccessful, or the result is compatible with the benign lesion or is indeterminate, six months and then yearly follow-ups are instituted.

All patients having irradiation are given suppressive doses of thyroid hormone unless this is contraindicated. It is somewhat controversial how long this therapy should continue after irradiation, but it is probably wise to continue it for at least 35 years in patients with normal thyroids and indefinitely in those with an abnormality of the thyroid.

Radioiodide therapy is strongly indicated in any patient with thyroid cancer and particularly in those with thyroid cancer occurring after radiation. Several studies in non-irradiated populations with thyroid cancer have shown that prognosis for patients treated with radioiodide is significantly better, both in terms of recurrence and death rate than with patients not treated with this entity.

SHORT BIBLIOGRAPHY

1. Favus, MJ, Scheider, AB, Stachura, ME, *et al.*: Thyroid cancer occurring as a late consequence of head-and-neck irradiation. Evaluation of 1056 patients. *New Engl. J. Med.* 294:1019, 1976.
2. Refetoff, S, Harrison, J, Karanfilski, BT, *et al.*: Continuing occurrence of thyroid carcinoma after irradiation to the neck in infancy and childhood. *New Engl. J. Med.* 292:171, 1975.
3. Roubesh, CP, Asteris, GT and DeGroot, LJ: The National History of Radiation-Associated Thyroid Cancer. *Archives of Internal Medicine* (in press), 1978.



Tagamet[®]

brand of

cimetidine

How Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).

Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
a SmithKline company

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION

Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of
Neosporin[®] Ointment (polymyxin B-bacitracin-neomycin).



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section)

Complete literature available on request from Professional Services Dept. PML.

Hemorrhagic Diatheses . . .

CONTINUED FROM PAGES 756-762

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.

ANSWER THE FOLLOWING:

- Which of the following is the most important in the investigation of a possible hemorrhagic disorder?
 - Lee and White.
 - APTT (activated partial thromboplastin time).
 - A detailed history.
 - Prothrombin time and bleeding time.
- H.R., a 47-year-old male, has a diagnosis of myeloproliferative syndrome. His platelet count is 1.5 million. He has a headache, nosebleed and phlebitis of the left cephalic vein. Which would be the most appropriate immediate treatment?
 - Nitrogen mustard—10 mg/m²—IV push.
 - Aspirin, nose pack and elevation of the left arm, plus a K-Pak.
 - Platelet phoresis.
 - Alkeran.
- J.S. is an asymptomatic 7-year-old female with ITP (idiopathic thrombocytopenic purpura). The platelet count is 3,000 per cubic mm. Generally, the usual initial therapeutic approach is:
 - Bedrest.
 - Splenectomy.
 - Platelet transfusion.
 - Corticosteroids.
- P.T. is a 26-year-old, 70-kg male with acute granulocytic leukemia. He has just completed a multidrug chemotherapy induction program and is having a profuse nosebleed. The platelet count is 8,000 per cubic mm. The most appropriate immediate treatment would be:
 - 2 units of platelet concentrate.
 - 10 units of platelet concentrate.
 - 30 units of platelet concentrate.
 - Corticosteroids.
- H.R.C. has a probable ruptured spleen. She has been on coumadin and the protime is therapeutically prolonged at two times control. The surgeon is poised with knife in hand. The most appropriate immediate therapy is:
 - A prayer.
 - 50 mg Vit K IV push.
 - Fresh frozen plasma.
- J.L. is an active 14-year-old male with mild classic hemophilia A. He stepped on a broken bottle and has a laceration of his right great toe, which requires three stitches. There is no active bleeding. Which of the following would be most appropriate?
 - Cryoprecipitate and 3 stitches.
 - 3 stitches and a carefully applied pressure dressing.
 - Factor 8 concentrate and 3 stitches.
 - 3 stitches.
 - Stitches and factor 8 replacement until primary wound healing.

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer sheet for Quiz: (Hemorrhagic Diatheses . . .)

- a, b, c, d
- a, b, c, d
- a, b, c, d
- a, b, c, d
- a, b, c
- a, b, c, d, e

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

The Division of Postgraduate and Continuing Medical Education must receive your completed, signed application before October 15, 1978, to be eligible for credit for this month's quiz. Answers to the quiz will appear in a later issue.

NEWS NOTES

Hospital Rate Increase Reduced 2.55%

The Indiana Task Force on Health Care Costs has reported a 2.55% reduction in the rate of increase in Indiana hospital expenses for January through May 1978. Dr. Eli Goodman, ISMA president and chairman of the Task Force, said, "This is a good indication that the Voluntary Effort is working in the hospitals in Indiana. This Task Force will keep a close watch on the reports for June and July to see if this trend continues." The reduction, which covers 33 hospitals whose annual budgets have been approved by the Indiana Hospital Rate Review Committee, represents 50% of the total hospital revenues of the state.

The Task Force has also granted provisional certification to 49 Indiana hospitals as "cost containment hospitals," indicating that the board of trustees and medical staff of each institution have "resolved to support the Voluntary Effort to restrain the rate of increase of health care expenses."

Leadership Award

Dr. Ivan T. Lindgren of Aurora has been presented an award for leadership among public health physicians. The presentation was made by the Indiana Public Health Association, of which Dr. Lindgren will serve as president-elect next year.

Elected to Fellowship

Dr. William L. Strecker of Terre Haute has been named a fellow of the American Society of Anesthesiologists. He is a 1947 graduate of the University of Illinois College of Medicine, Chicago.

Earns Silver Beaver Award

Dr. Robert M. Sweeney, a South Bend pediatrician, was one of six Northern Indiana Council scout leaders who were awarded the Silver Beaver for "exceptional service" to boys in the Cub Scout, Scout and Explorer programs. Dr. Sweeney, a scouting leader since 1967, has been a Cub pack chairman, scoutmaster, and an Explorer post adviser. For the past two years he has been the council's high adventure chairman.

'Museum Notes' Author Honored

Dr. Charles A. Bonsett of Indianapolis, author of *The Journal's* monthly "Medical Museum Notes" (see page 725), was one of eight persons recently honored by the Marion County Muscular Dystrophy Foundation for 20 years of service with the organization. Dr. Bonsett is volunteer research director for the Foundation and for the Indiana Neuromuscular Research Laboratory.



MALPRACTICE INSURANCE AVAILABLE

Owned by
PHYSICIANS

Operated by
PHYSICIANS

For the protection of
PHYSICIANS



Physicians & Surgeons Liability Insurance Co., Inc.
800 MacArthur Boulevard / Munster, Indiana 46321
219 836-2288

NEWS NOTES

8 More States Join Jail Project

The AMA has announced that eight states and the District of Columbia have been added to the original six states in the program of minimum health and medical standards for jails. The new states are Illinois, Massachusetts, Nevada, Ohio, North Carolina, Pennsylvania, South Carolina and Texas. A total of 26 jails in the six original states, of which Indiana was one, have been accredited. The program is funded by the Law Enforcement Assistance Administration of the U.S. Justice Department.

The National Institute of Corrections provided funds to the AMA for production of a course outline and a manual to train jailers to recognize common illnesses for the purpose of separating sick from healthy persons. The course also teaches certain fundamental emergency medical care techniques. Such jailer training was conducted in Evansville in June, with 26 jailers from 12 sheriff departments completing it. ISMA and the Indiana Sheriffs Association jointly sponsored the training.

4 Indiana Jails Accredited

The Greene County jail, originally accredited during the summer of 1977, was one of five jails across the country to be granted a two-year accreditation by the National Advisory Committee of the AMA. Other county jails in Indiana receiving a one-year accreditation were those in LaPorte, Allen and Vanderburgh Counties. A total of six jails have now been accredited by the AMA in Indiana.

Accreditation is given those jails that meet the AMA's 82 standards, designed to help jails meet medical and legal criteria. These standards call for physical examinations; better medical, dental and mental health care; alcohol and drug user rehabilitation; better medical record-keeping; and stricter drug prescription practices.

The jail physicians at the newly accredited facilities are Dr. William R. Powers, Greene County; Dr. Clement H. Elshout, LaPorte County; Dr. Dean Elzey, Allen County; and Dr. John S. Farquhar, Vanderburgh County.

I.U. Honors Scamahorn Family

Three generations of the Scamahorn family of Pittsboro were honored during an Alumni Day program marking the 75th anniversary of the I.U. School of Medicine, which admitted its first class in Bloomington in September 1903. The Distinguished Alumni Family Award was presented to the late Oscar T. Scamahorn, M.D., 1908 graduate; his son, Malcolm O., M.D., 1943; and his son, James Oscar, M.D., 1976. Twelve other families also received the award.

Five Scholarships Awarded

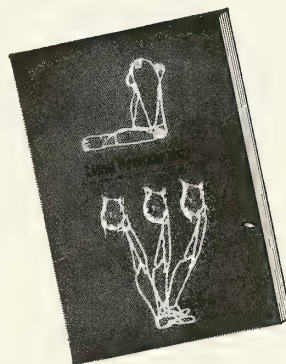
The Howard County Medical Society and Auxiliary have awarded scholarships to five county graduates pursuing careers in health care.

'Blindness and Diabetes' Pamphlet

A person who has lost the ability to see because of diabetes can live independently and successfully if he or she has been trained. "Blindness and Diabetes" is a pamphlet published by the American Foundation for the Blind. It outlines the things a diabetic patient should be taught. "Devices for Visually Impaired Diabetics" is published by the American Foundation and the New York Diabetes Association for the purpose of teaching the blind how to measure insulin in a syringe. Both pamphlets are available without cost from the American Foundation for the Blind, 15 West 16th St., New York City, 10011.

Plymouth Physician Cited

Dr. J. Kent Guild of Plymouth received the 1978 DePauw University Rector Scholar Achievement Award during alumni ceremonies on the Greencastle campus. The award is presented for Christian service, leadership and accomplishment since graduation. Dr. Guild has served two terms as a member of DePauw's alumni board and has been president of the Plymouth area DePauw Alumni Association.



HANGER PROSTHESES OFFERS BOOKLET ON AMPUTATIONS

This booklet has been designed for those physicians whose practice includes amputation. Limb Prosthetics gives ready reference for each site of amputation as well as the prostheses recommended for each site.

Over 100 years of experience gained by the Hanger organization have gone into this carefully illustrated booklet. Illustrations include amputation sites for the leg and the arm, various Hanger prostheses and methods of suspension, post-operative care and preparation for prosthesis, plus selected photographs showing the child amputee and training for the above-knee patient.

We believe that you will find Limb Prosthetics a most useful booklet and a valuable source of quick information. To obtain your copy, please write or phone the Hanger office nearest you.

Hanger
PROSTHESES

1332 N. Illinois St., Indianapolis, Indiana 46202
312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

Physician Recognition Awards

The following ISMA-member physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Adams, Parks, M., N. Manchester
Ali, Syed Abrar, Boonville
Barton, Robert F., Angola
Beach, Norman F., South Bend
Bellis, Stephen L., Bloomington
Billena, Raymundo L., Merrillville
Bougher, Gerald R., Lafayette
Brown, James R., Valparaiso
Brown, Wendell E., Indianapolis
Caplin, Irvin, Indianapolis
Gheng, Sylvia Siu-Fan, Walton
Chua, Gonzalo Tan, Indianapolis
Collier, John W., Bedford
Cortese, Thomas A., Indianapolis
Divcic, Borivoz S., Valparaiso
Faw, Melvin L., Evansville
Ferguson, James F., Bloomington
Ferguson, William B., Lafayette
Fisher, Thomas F., Valparaiso
Fox, Jack M., Munster
George, Charles L., Indianapolis
Godsey, Phillip D., Fort Wayne

Gourieux, Edward D., Evansville
Grove, Dean A., Carmel
Hallal, Eli, New Albany
Healey, Robert J., Indianapolis
Henry, Alvin L., Columbus
Hickman, Donald M., Fort Wayne
Holliday, Alfonso D., Gary
Holm, Byron M., Plymouth
Htain, Min, Terre Haute
Johns, Janet S., Lafayette
Jones, David H., Charlestown
Kane, Jack L., Indianapolis
Kaye, Robert C., Rensselaer
Keating, John U., Indianapolis
Lambert, Destry W., Tipton
Lucas, Owen R., Chesterton
Maroc, James A., Munster
Marshall, Thomas W., Columbus
Mazdai, A., Connersville
McCaslin, Dan L., Fort Wayne
McQuade, John A., South Bend
Miller, Edward D., Fort Wayne

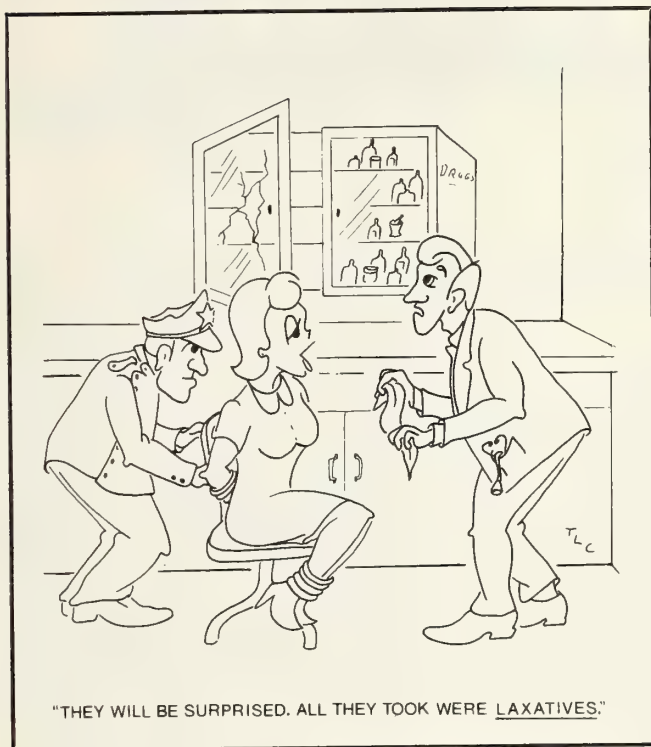
Miranda, C. R., Winchester
Mulford, Robert H., Muncie
Naval, J. C., South Bend
Newnum, Raymond L., Evansville
Palmer, Barron M. F., Hammond
Pickerill, James M., Lafayette
Reimers, Roger A., Bloomington
Scherer, Jack R., Columbus
Scupham, William K., LaPorte
Sekulich, Milo M., Kokomo
Smith, John A., Indianapolis
Spain, W. Thomas, Evansville
Spellmeyer, John C., Richmond
Sun, Chen Tung, Hebron
Thurston, John B., Indianapolis
Triplett, Douglas A., Muncie
Vaughn, Walter R., Vincennes
Villa, Florencio C., Union City
Warren, John R., Carmel
Waymire, W. Merle, Franklin
Webster, Paul L., Lafayette
Wheeler, Byron C., Terre Haute
Woodward, William M., Westville

FOR SALE

ALBANY, INDIANA—Retiring medical doctor's residence and office. Established 50-year general practice. Located in town of 2,500 population with growing community. Situated within 12 miles of all modern hospital. A beautiful 2-story home with 9 rooms, fully carpeted down with hardwood floors up. Formal dining room, family room, living room, kitchen with glassed in breakfast room, 2 ceramic baths, all nicely decorated. Full basement with doctor's office, 3 finished rooms with separate entrance and garage. Gas heat with central air. Also a 2-car garage with electric opener. Nice fenced in yard with trees. TOM D. FLESHER, REALTOR—205 West State Street, Albany, Indiana 47320. Phone (317) 789-6162.



NEWS NOTES



Back from Kenya

Dr. Ian S. Templeton of Seymour has completed a six-week medical mission to Kenya. While in the east African country, he worked in a 140-bed hospital in Sotoc. He was accompanied on the trip by his daughter Sara, 14.

Diplomates Named

The following ISMA-member physicians have been named diplomates of the American Board of Family Practice:

Dr. Walter P. Beaver, Noblesville;
 Dr. William B. Hughes, Waterloo;
 Dr. George R. Kiracofe, Richmond;
 Dr. Luke B. Mosemann, Paoli;
 Dr. Ronald K. Stegemoller, Danville;
 Dr. William G. Terpstra, Noblesville.

Elections

Dr. Larry H. Beisel of Evansville has been named president of the Welborn Hospital medical staff. Dr. Melvin Faw was named president-elect and Dr. Mell Welborn Jr., secretary-treasurer.

Dr. Robert E. Hanneman of West Lafayette has been elected to a second term as chairman of the Indiana Section, American Academy of Pediatrics.

New officers of the Indiana State Coroners Association include Dr. Karl L. Manders, Marion County coroner, vice-president, and Dr. Albert T. Willardo, Lake County coroner, secretary-treasurer. Marjorie Eller, Clinton County coroner, was elected president.

Dr. Ned B. Hornback, professor and chairman of the Department of Radiation-Oncology, I.U. School of Medicine, has been elected president of the Little Red Door, Marion County Cancer Society. Dr. Virginia M. Wagner was elected vice-president.

Dr. James W. Jackson of Fort Wayne has been named president of the American Heart Association's Allen Branch.

Dr. Glen A. Ramsdell of Richmond has been named president of the American Lung Association of Indiana.

Golden Apple Award

Dr. Thomas F. LaVelle of South Bend was presented the Golden Apple Award by recent graduates of the three-year family practice program at St. Joseph Hospital. He was credited with being "an outstanding educator and resource person."

Honorary Doctorates Presented

Honorary doctorates were awarded by Calumet College recently to Dr. James P. Comer, associate dean of the Yale Medical School, and to Dr. Henry W. Eggers, who retired two years ago after 47 years as a Hammond physician. Dr. Comer, a native of East Chicago, is the author of "Beyond Black and White" and has worked with the Children's Television Workshop, which produces "Sesame Street" and the "Electric Company." Dr. Eggers, honored in 1974 as "Outstanding Doctor in Indiana," is a founding member of the American College of Obstetrics and Gynecology.

INDIANA MEDICAL BUREAU

1010 East 86th St.—72 Winterton

Indianapolis 46240

844-7933

*A Licensed Employment Agency
 Specializing in Medical Personnel*

Our 26th Year of Service

BOOK REVIEWS



The Doctor Game (A Novel)

Howard A. Olgin, M.D., 1978, J. B. Lippincott Co., 521 Fifth Ave., New York, N.Y. 10017, 296 pages, \$8.95.

The story concerns three medical students in Philadelphia. One is kicked out of his residency and becomes an M.D. malpractice lawyer, one is a girl who marries him, and the third is the fictionalized author of the book, who now practices surgery in California. He performs the Whipple operation on a Jewish man who, it turns out, does not have the expected cancer of the pancreas. The patient dies post-operatively and his terminally ill daughter sues, using the surgeon's former friend, Moe Michener, the doctor-lawyer. This forms the basis for dramatic tension between the characters, while a distracting subplot involves the surgeon's burgeoning romantic interest in his secretary.

This seems to be an intriguing plot and the author organizes and develops it commendably. The problem concerns realism and what can be called verisimilitude. The book is written very

realistically—I couldn't get the author out of my mind while reading it. But it lacks the dynamic reality that is the keystone of good fiction. It must not be just as life; it must be larger than life. The dialogue by Dr. Olgin tends toward self-consciousness and the characters aren't subtle. In short, there is a lack of verisimilitude, but not a complete lack.

Nevertheless, all this is not to say that a doctor wouldn't enjoy reading the book. I certainly did. The scatological language is a barrier easily overcome, and the plot is very interesting medically. That the surgeon is let off at the end and the villain is dealt with is a bonus for the physician reader. I anticipate a good second novel from the author after his further assimilation of the fictional genre and its ineffable complexities.

RODNEY A. MANNION, M.D.
Urological Surgeon
LaPorte

BE THE
DOCTOR
YOU WANT
TO BE
IN THE NAVY

For more information,
call toll-free 800-841-8000
(in Georgia: 800-342-5855)
or see your local
Navy representative.

When it comes
to nuclear training,
no one can give you
a better start.

In the Navy, it's not just a job.
It's an adventure. For more
information, call toll-free 800-841-8000
(in Georgia: 800-342-5855) or see your
local Navy representative.

BOOK REVIEWS

Diabetes Mellitus: Theory and Management

Petrides, et al., translated by D. H. Williamson, Oxford. 1978, Urban and Schwarzenberg, 7 E. Redwood St., Baltimore, Md. 21202, 143 pages, \$12.50

As an active practicing Internist, with special interests in the diagnosis and treatment of diabetes for 41 years, I find this to be the most informative and up-to-date publication in the overall coverage of diabetes I have ever read. This belief is best expressed in the Foreword, by Hans A. Krebs:

"This translation of the third German edition is a most welcome addition to the English literature on diabetes. . . . The book covers the biochemical basis and the pathogenesis of diabetes, the study of experimental diabetes and the clinical aspects. The four authors between them have extensive experience in all aspects of diabetes and their close collaboration has resulted in a work of high standard. Its conciseness is a special attraction to the busy clinician."

The first chapter deals with the newest approach to the cause of diabetes. Years of research have been directed toward determining, "why is a diabetic" and attempting to cure this third most disabling disease. It has always been noted that diabetes mellitus is a disturbance of carbohydrate metabolism with the associated secondary fat and protein dysfunction due to the disturbance of cellular metabolism. The consideration of the cause of the basic change has been directed toward a better evaluation of the biochemistry of the hormones concerned with diabetes. The in-depth investigation of the hormone action, other than insulin, has brought about a reappraisal of the actual process which is undergoing in the diabetic. The chapter explains the various hormones, sites of the hormone action, chemistry of insulin, action

of insulin, association of the other glands of internal secretion and the overall cause and metabolic changes which precipitate diabetes.

The chapter on manifestation factors leading to the appearance of diabetes stresses the importance of overeating. It is historically documented that there is a close correlation between obesity and the frequency of diabetes. Cumulative stress situations, infections, trauma, surgery, pregnancy, pancreatic and liver diseases and the use of glucocorticoid and diuretics in excess can likewise bring about the impairment of glucose tolerance and the premature occurrence of the diabetic state.

The section on definition and classification of the types of diabetes is very well covered and aids in better understanding the clinical aspects of diabetes mellitus. This discussion leads into the treatment of diabetes. Although the basic plan has not changed in many years, the most recent adaptation of a more sophisticated and more reliable method in the treatment plan has been emphasized.

The problems of the diabetic—life-style, employment, insurance, drivers license and the underlying psychological aspect of trying to live "just like others"—is thoroughly considered in this book. It was of special interest to review the overall concept of the management of the diabetic in this country with that of our foreign colleagues.

I recommend this publication to all family practice physicians, all internists and especially the diabetologists.

IRVIN W. WILKENS, M.D.
Internist
Indianapolis

ISMA ANNUAL MEETING
October 22-25 • Clarksville

BOOK REVIEWS

Medical Genetic Studies of the Amish

Victor A. McKusick, M.D., 1978, The Johns Hopkins University Press, Baltimore, Md. 21218, 525 pages, \$27.50.

This book consists of selected papers assembled and commented upon by the author. The study of the results of extensive inbreeding originated with a manuscript of John Hostetler's *Amish Society*.

Traits described in the book are largely of recessive disease resulting from the closed nature of Amish groups; persons leave the community, but almost no one enters. The Amish are descendants of a limited number of immigrant founders.

Considerable historical material concerning the Amish sect, which originated in 1693 in Switzerland, is described. Distribution of genes in the Amish is discussed—geneologic records were reliable—and a host of abnormalities, many of which are really tragic, are related.

The book, of particular interest to those concerned with the Amish or with genetic studies, contains numerous geneologic charts and a generous number of excellent photographs.

W. D. SNIVELY, JR., M.D.
Internal Medicine
Evansville



LET US GIVE YOU A LIFT...

Yellow Medi-Car service is now available to all persons confined to a wheel chair. If a person is ill, handicapped, physically limited or aged and must use a wheel chair, the new non-scheduled van service of Yellow Medi-Car is available with prior notice or by 24 hour reservation. These new modern vans with a level, hydraulic lift can be used to transport wheel chair passengers to work, shopping, visit relatives and friends, obtain medical treatment or medicine, and to attend church and recreational events.

SERVICE AREAS:

Indianapolis and Marion,
Boone, Madison, Hamilton,
Hendricks, Johnson, Morgan,
Hancock and Shelby Counties.



Yellow Medi-Car

FOR FURTHER INFORMATION
CALL 637-5421
WE MAKE
HOUSE CALLS!!

Where people come first

Pulmonary Tuberculosis . . .

CONTINUED FROM PAGES 763-770

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.

ANSWER THE FOLLOWING:

- Approximately how many new cases of tuberculosis (Class III) were reported in Indiana in 1976?
 - 100
 - 500
 - 300
 - 1,200
 - 3,500
- Which of the following may reduce the infectiousness of a patient with pulmonary tuberculosis?
 - Adequate ventilation
 - Properly placed ultraviolet lights
 - Mouth coverage during coughing
 - Chemotherapy
 - all of the above
- Approximately how long does it take for a patient with active pulmonary tuberculosis to become non-infectious following initiation of effective chemotherapy?
 - 24 hours
 - six months
 - three days
 - two to three weeks
 - none of the above
- A patient with newly discovered active pulmonary tuberculosis (Class III) should be started on which one of the following?
 - Isoniazid alone pending sensitivity results
 - Streptomycin and Para-aminosalicylic acid (PAS)
 - Isoniazid and ethambutol and/or rifampin
 - No drugs until sensitivity results are available
 - none of the above
- Approximately what fraction of patients who complete a course of effective antituberculous chemotherapy will have relapse of their disease?
 - 20%
 - 2-4%
 - 13%
 - 35%
 - 0.1%
- Evaluation of patient response to antituberculous chemotherapy is best made by:
 - Serial chest roentgenograms
 - Clinical history and physical examination
 - Repeated weights
 - Serial sputum smears and cultures for tuberculosis
 - Sputum tuberculosis sensitivity testing

The following are answers to the CME quiz that appeared in the May 1978 issue of *The Journal*. The article upon which the questions were based was "Complications of Acute Anterior Myocardial Infarction," by R. Joe Noble, M.D. and J. Stanley Mills, M.D.

- | | | |
|------------|------------|----------------|
| 1. b | 6. a, b, c | 10. a |
| 2. a, b, d | 7. a, b, c | 11. a, b, c |
| 3. b, c | 8. a, b, c | 12. c |
| 4. c, d | 9. a, b, c | 13. a, b, c, e |
| 5. b, e | | |

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer sheet for Quiz: (Pulmonary Tuberculosis . . .)

- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

The Division of Postgraduate and Continuing Medical Education must receive your completed, signed application before October 15, 1978, to be eligible for credit for this month's quiz. Answers to the quiz will appear in a later issue.

FUTURE FILE

Illinois CME Symposia

Symposia sponsored by Southern Illinois University School of Medicine in October include:

Oct. 5: Diabetes Mellitus (4 hours—Mt. Vernon).

Oct. 7: Neurology Update (4 hours—Pittsfield).

Oct. 19-21: Fifth Annual Family Practice Symposium (Springfield).

Oct. 26: Medical and Surgical Approaches to Acute Colon and Rectal Diseases (4 hours—Hillsboro).

Oct. 28: Fourth Annual Medical Photography Workshop (6 hours—Springfield).

Three-Day Pediatrics Seminar

"Solving Difficult Problems in Ambulatory Pediatrics: A Multidisciplinary Approach" will be the subject of the First Annual Department of Human Development Seminar of the College of Human Medicine, Michigan State University Sept. 21-23 at The Kellogg Center for Continuing Education. The course is designed for primary care physicians in pediatrics. Good for 16 hours CME Category I credit. Write: Conferences and Institutes, 50 Kellogg Center, MSU, East Lansing, Mich. 48824.

International Scientific Assembly

The 63rd Annual International Scientific Assembly of the Interstate Postgraduate Medical Association will be held at the Washington, D.C. Hilton Hotel Oct. 23-26. The program is designed for Primary Care Physicians. The meeting is open to any licensed physician in the U.S. and Canada for a fee of \$75 in advance or \$100 at the meeting. For information and hotel forms, write to Alton Ochsner, M.D., P.O. Box 1109, Madison, Wisconsin 53701.

Michigan CME Conferences

The University of Michigan Medical School will offer the following continuing education courses, acceptable for Category I credit. For information on fees and registration, write the Office of Continuing Education, University of Michigan Medical School, the Towsley Center, Ann Arbor, Mich. 48109.

Sept. 19-22: "Blood Coagulation," for medical technologists and pathologists.

Sept. 27: "A Symposium on the Fetal Alcohol Syndrome," for pediatricians, Ob-Gyn, family physicians, psychiatrists, nurses.

Sept. 29: "Parenteral Hyperalimentation," for surgeons, internists, family physicians, nurses, pharmacists, dietitians.

Pediatric Care Symposium

The I.U. School of Medicine and the James Whitcomb Riley Hospital for Children will sponsor the sixth annual pediatric surgical fall symposium Oct. 4-5 at the Hyatt Regency Hotel, Indianapolis.

Topics for the symposium, called "Progress in Pediatric Care," will include neonatal aspiration, oxygen therapy, hematuria, tracheal stricture, x-ray evaluation, spinal deformities, anesthesia, juvenile diabetes, leukemia, Wilms' tumor, intussusception, seizure disorders, pediatric cardiology, gastroesophageal reflux, esophageal atresia, and ophthalmologic, dermatologic and urologic disorders.

The symposium is approved by AMA for 13 hours of post-graduate credit.

For information, contact the symposium director, Jay L. Grosfeld, M.D., surgeon-in-chief, James Whitcomb Riley Hospital for Children, Rm. K-21, 1100 W. Michigan St., Indianapolis 46202.

Indiana University CME Offerings

Sept. 6: Pediatrics for Primary Care Physicians (Kokomo);

Sept. 8-9: Pediatric Ophthalmology (Indianapolis);

Sept. 20: Ophthalmology for Primary Care Physicians (Kokomo);

Sept. 27-29: Advanced Echocardiography (Indianapolis);

Sept. 29: Epilepsies (Indianapolis);

Oct. 4-5: Critically Ill Child (Indianapolis);

Oct. 12: Infections—Medical and Surgical Management (Richmond);

Oct. 18: Clinical Neuro-Ophthalmology (Indianapolis);

Oct. 28: Coronary Emergencies (Lafayette);

Oct. 26-28: Garceau-Wray Orthopedic Lectures.

For further information, write or call the Indiana University School of Medicine, Division of Postgraduate Medical Education, 1100 W. Michigan St., Indianapolis 46202. (317) 264-8353.

Medical Assistants to Meet

The American Association of Medical Assistants will meet Sunday, Sept. 10, at the Holiday Inn Northeast, 6990 Pendleton Pike, Indianapolis, to discuss "Law and the Medical Assistant." Registration will begin at 8 a.m., and lunch will be served. The fee is \$12. For more information on this meeting, keyed to both physicians and their assistants, contact Mrs. Lori Cravens at the Professional Careers Institute, Indianapolis, (317) 299-6001.

ISMA ANNUAL MEETING
October 22-25 • Clarksville

COMMERCIAL ANNOUNCEMENTS

Commercial announcements are carried in The Journal as a special service to ISMA members. Only advertisements considered by publisher to be of advantage to members will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

20¢ for each word

\$4.00 minimum

Send cash with order. Average count: seven words to the line.

Address: The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

DEADLINE: Fifth day of month PRECEDING month of issue.

RETIRED or physically restricted or limited practice physicians as **MEDICAL DIRECTORS** of plasma center in West Lafayette area. Call Mr. Reiland at (317) 924-6336, PLASCON, INC.

COLORADO MOUNTAIN VALLEY FOR SALE. Equidistant from Breckenridge, Denver, Colorado Springs. Abuts on Pike National Forest. Perfect, very private retreat. Contact Hay Creek Ranch, P.O. Box 1214, Breckenridge, Colo. 80424.

PHYSICIANS' ASSISTANT with National Certification and Family Practice and Surgery experience is interested in a Family Practice, a Surgery, or an Emergency Room opportunity. Prefers group practice, but would consider a private practice. Contact Steven M. Trimble, P.A.-C., 353 State St., Wabash, Ind. 46992.

FOR SALE: Modern office, 1,056 square feet, on choice business lot in town. Established practice of 48 years. Will sell outright or on short term contract. Private parking, four treatment rooms, waiting room, reception, drug, storage and bathroom. Location south central Indiana, State Road 37, 40 miles south of Bloomington, 55 miles northwest of Louisville. Office phone (812) 865-3350, residence (812) 865-3351.

OPPORTUNITIES FOR PHYSICIANS—There are several excellent openings among the Indiana State Hospitals at various locations throughout the State for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Candidates must be licensable in Indiana. Please reply with a copy of the c.v. to: FARABEE & ASSOCIATES, INC., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

PHYSICIAN'S OFFICE AVAILABLE—Has been physician's office for last 8 years. Eastside, 5 minutes from St. Francis and Community Hospitals. All utilities except phone. American alarm, private parking, large waiting room. (317) 357-7657 or 357-2403.

THE INDIANA STATE DEPARTMENT OF PUBLIC WELFARE has a position available for a physician to work in a pleasant office atmosphere; no patient contact; no malpractice insurance required; an Indiana license or eligibility is required; competitive salary; regular working hours; excellent fringe benefits. Contact: Personnel Director, Indiana State Department of Public Welfare, 702 State Office Building, 100 N. Senate Ave., Indianapolis 46204. Phone: (317) 633-6403.

FAMILY PRACTICE: Board certified/eligible family practitioner needed by large multi-specialty group in northwest Ohio. Perfect opportunity for right individual to establish satellite practice in conjunction with a well established large group practice. Top salary and fringes being offered as a member of the group, along with other corporate benefits. Please forward curriculum vitae, salary requirements to Box J, The Journal.

ORTHOPEDIC SURGEON: Board certified/eligible orthopedic surgeon needed by well established, 42-physician multi-specialty group in northwest Ohio. Major regional medical center with large referral base. Staff includes four Rheumatologists. Top salary, excellent fringe benefit program along with all corporate benefits. Please forward current curriculum vitae, salary requirements to Box J, The Journal.

PHYSICIAN with empathy toward college-age population to practice general medicine in 38-bed accredited hospital with large outpatient clinic. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., director, Purdue University Student Hospital, West Lafayette, Ind. 47907. (317) 749-2441.

EXCELLENT OPPORTUNITY—Physician—for Disability Determination Division, Indiana Rehabilitation Services. No insurance requirements, no patient load, low-pressure atmosphere, excellent fringe benefits. Contact the Personnel Officer, 1-317-633-6828, or write above agency at Room 1010 Illinois Bldg., 17 W. Market St., Indianapolis 46204.

TAX ADVANTAGED LEASING—Fixtures, equipment, machinery, furniture and automobiles. Accelerated depreciation with investment tax credits. (317) 291-9342.

ISMA ANNUAL MEETING

October 22-25 • Clarksville

PHYSICIANS' DIRECTORY

INTERNAL MEDICINE

Offices for the doctors listed below are located at 3130 N. Meridian St., Indianapolis 46208; the switchboard number is 317-927-1221.

MERIDIAN MEDICAL GROUP

CARDIOLOGY

Richard M. Nay, M.D.
Warren E. Coggeshall, M.D.
Richard R. Schumacher, M.D.
William C. Elliott, M.D.

HEMATOLOGY—ONCOLOGY

Laurence H. Bates, M.D.
William M. Dugan, M.D.
James E. Schroeder, M.D.
Frank A. Workman, M.D.
Deborah S. Provisor, M.D.
Pediatrics

METABOLISM AND ENDOCRINOLOGY

William M. Holland, M.D.

GASTROENTEROLOGY

Robert D. Pickett, M.D.
B. T. Maxam, M.D.
Lee G. Jordan, M.D.
Martin P. Meisenheimer, M.D.

INTERNAL MEDICINE

Hunter A. Soper, M.D.
Douglas H. White, Jr., M.D.
Michael B. DuBois, M.D.

Nephrology

Michael P. Bubbs, M.D.
Robert L. Iverson, Jr., M.D.

Critical Care

Michael Zeckel, M.D.
Infectious Diseases

INFECTIOUS DISEASES

Thomas G. Slama, M.D.

NEUROLOGY

Norman W. Oestrike, M.D.
Charles Rehn, M.D.

NEUROSURGERY

By Appointment

Phone 925-4255

C. BASIL FAUSSET, M.D.

Neurological Surgery

1815 North Capitol Avenue

Indianapolis 46202

By appointment only

Phone 317-353-6800

BIO MEDICAL LABORATORY

5506 East 16th St., Suite 24

Indianapolis 46218

Bio-Feedback Training for Migraine and Tension Headache

KARL L. MANDERS, M.D.

JOHN S. MARKS, JR., M.D.

MALCOLM S. SNELL, M.D.

PLASTIC SURGERY

NEPHROLOGY & INTERNAL MEDICINE, INC.

Daniel J. Ahearn, M.D.
Thomas Wm. Alley, M.D., FACP
George W. Applegate, M.D.
Charles B. Carter, M.D.

William H. Dick, M.D., FACP
Theodore F. Hegeman, M.D.
Douglas F. Johnstone, M.D.
LeRoy H. King, Jr., M.D., FACP

2020 W. 86th St., #307, Indianapolis 46260 Ph: 317-844-9911
1633 N. Capitol, #722, Indianapolis 46202 Ph: 317-926-0757

Answering Service 926-3466

CLINICAL NEPHROLOGY, RENAL TRANSPLANTATION, HEMODIALYSIS, PERITONEAL DIALYSIS, HYPERTENSION, FLUID AND ELECTROLYTE IMBALANCE, CRITICAL CARE.

PLASTIC & HAND SURGERY CLINIC, INC.

1944 N. Capitol Ave.

Indianapolis 46202

"An office surgery facility"

Haroon M. Qazi, M.D.

Diplomate, American Board of Plastic Surgery

Phone: 317-923-4822

317-926-3466

HAND SURGERY

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

By appointment

Phone 317-783-1319

VIDYASAGAR S. TUMULURI, M.D., F.A.C.S., INC.

Diplomate American Board of Surgery

Acute & Reconstructive Hand Surgery

General Surgery

3530 S. Keystone, Suite 305

Indianapolis 46227

PHYSICIANS' DIRECTORY

PSYCHIATRY

JOHN H. GREIST, M.D.

Diplomate, Board of Neurology and Psychiatry

Specializing in Psychiatry

3231 North Meridian Street

Indianapolis 46208

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALLERGY

INDIANA ASTHMA & ALLERGY ASSOCIATES

Specializing in Chronic Severe Asthma

and

Adult and Pediatric Allergic Disorders

D. Duane Houser, M.D., Inc.

(317) 923-7650

and

Douglas J. Horton, M.D.

(317) 923-6990

1815 N. Capitol Avenue
Indianapolis, Indiana 46202

Diplomates, American Board
of Allergy & Immunology

Answering Service 926-3466

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

Since 1899

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Southern Indiana Office: Kenneth W. Moeller, Representative
1810 Broad Ripple Avenue Telephone: (317) 255-6525
Mailing Address: P.O. Box 20132, Indianapolis 46220
Northern Indiana Office: Douglas O. Sellon, Representative
120 LaSalle West Bldg., Suite 304
South Bend, In. 46601 Telephone: (219) 289-7332

OBITUARIES

Harold Hall Davidson, M.D.

Dr. Davidson, 56, an Evansville physician, died May 1 at Welborn Memorial Baptist Hospital, Evansville.

He was a 1945 graduate of Vanderbilt University School of Medicine, and was a diplomate of the American Board of Obstetrics and Gynecology.

Dr. Davidson was a former president of the Welborn Hospital medical staff and was acting secretary-treasurer of the Welborn Clinic at the time of his death.

Bertrand H. Puskamp, M.D.

Dr. Puskamp, 77, Wolcottville, died May 22 in St. Joseph Hospital, Fort Wayne.

He was a 1925 graduate of St. Louis University Medical School and became a senior member of the Indiana State Medical Association in 1971.

Dr. Puskamp had been engaged in general practice in LaGrange and Noble County for many years.

Victor A. Teixler, M.D.

Dr. Teixler, 67, an Indianapolis ophthalmologist since 1944, died June 11 in Methodist Hospital, Indianapolis.

He was a 1938 graduate of Indiana University School of Medicine and was a former president of the Marion County Ophthalmologists and Otolaryngologists Association.

Dr. Teixler was a fellow of the American College of Surgeons and a diplomate of the American Board of Ophthalmology. He was a clinical instructor in ophthalmology at Indiana University.

**NOW YOU CAN
LEASE
THE CAR YOU ALWAYS
WANTED TO OWN**



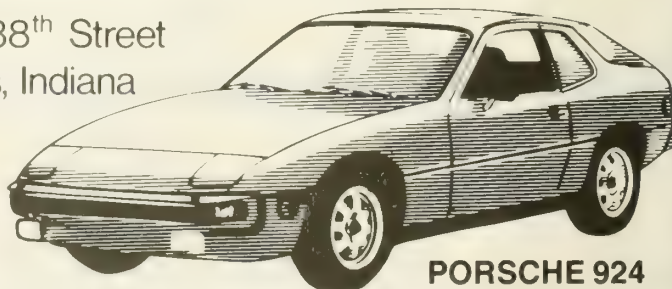
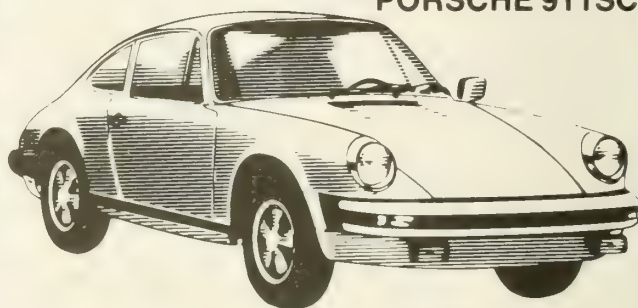
GIGANTI

INC.

6901 East 38th Street
Indianapolis, Indiana
545-4211

**INDIANAPOLIS' ONLY
PORSCHE AUDI DEALER**

PORSCHE 911SC



PORSCHE 924

COUNTY MEDICAL SOCIETY DIRECTORY

County	President	Secretary
Adams	John E. Doan, Decatur	Hyung Soo T. Lee, 227 S. Second St., Decatur 46733
Allen (Fort Wayne)	Jerald L. Andrew, Fort Wayne	Robert W. Dettmer, 2828 Fairfield Ave., Fort Wayne 46806
Bartholomew-Brown	Robert G. Reed, Columbus	Mr. Larry L. Pickering, Exec. Dir., 212 Med. Ctr. Bldg., Fort Wayne
Benton	A. L. Coddens, Earl Park	Stanley R. Adkins, 380 Plaza Drive #D, Columbus 47201
Boone	Donald Boyer, Lebanon	Manley K. Scheurich, R.R. 1, Oxford 47971
Carroll	Stephen C. Mayers, Flora	John J. Saalwaechter, 404 W. Camp St., Lebanon 46052
Cass	Joseph Howard, Logansport	Robert Seese, 101 W. North St., Delphi
Clark	Joselito Millan, Jeffersonville	Carl R. Boyd, 2 Chase Park, Logansport 46947
Clay	Robert C. Oehler, Brazil	Jerrold E. Tomlin, 1220 Spring St., Jeffersonville 47130
Clinton	Milton Erdel, Frankfort	E. L. Conrad, 1207 E. National Ave., Brazil
Daviess-Martin	Marshall Seat, Washington	William R. Stapleton, 1256 S. Jackson, Frankfort 46041
Dearborn-Ohio	Henry Conrad, Lawrenceburg	James P. Beck, 1312 Bedford Rd., Washington 47501
Decatur	Gene P. Gebele, Greensburg	Gerald T. Bowen, 705 Tanner Ave., Lawrenceburg 47025
DeKalb	John C. Harvey, Auburn	Arnold D. Ducanes, 215 N. Franklin St., Greensburg 47240
Delaware-Blackford	David J. Dietz, Muncie	Harland V. Hippensteel, 208 W. 7th St., Auburn 46706
Dubois	Allen D. Scales, Huntingburg	Chas. J. Leiphart, 320 W. Adams St., Muncie 47305
Elkhart	Donald L. Minter, Gashen	Phillip R. Dawkins, 507 W. 7th St., Jasper 47546
Fayette-Franklin	Joseph L. Steinem, Connorsville	Page E. Spray, 320 W. High St., Elkhart
Floyd	William V. Croft, New Albany	Kirit T. Patel, 1941 Virginia Ave., Connorsville 47331
Fountain-Warren	Hugh C. Brenner, Williamsport	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fulton	James P. Schalliol, Rochester	Theodore Person, 601 N. Mill St., Veedersburg
Gibson	William Wells, Princeton	Joseph D. Richardson, 121 West 8th St., Rochester 46975
Grant	L. J. Wojcik, Marion	Hassan Rayes, 1814 Sherman Dr., Princeton 47670
Greene	Robert Moses, Worthington	E. S. Rifner, Van Buren
Hamilton	A. Adrian Lanning, Noblesville	Harry Rotman, Jasonville
Hancock	Carl K. Matlock, Greenfield	Paul M. Waitt, 450 Lafayette Rd., Noblesville 46060
Harrison-Crawford	Louis M. Blessinger, Corydon	Gary C. Sharp, 120 W. McKenzie, Greenfield 46140
Hendricks	Joseph Kerlin, Danville	Carl E. Dillman, Beaver & Oak St., Corydon 47112
Henry	David Cain, New Castle	Wm. A. Edwards, 1655 Hawthorn Dr., Plainfield 46168
Howard	G. M. Reul, Kokomo	Donald E. Vivian, Henry Co. Hospital, New Castle 47362
Huntington	William J. Webb, Huntington	Donald L. Fields, 3804 Southland Ave., Kokomo 46901
Jackson	Mark M. Bevers, Seymour	Piyush J. Shah, 1159 Etna Ave., Huntington 46750
Jasper	Kenneth J. Ahler, Rensselaer	Joel M. McGill, 213 E. Cross St., Brownstown 47220
Jay	James S. Fitzpatrick, Portland	Michael Louck, 828 W. Washington Ave., Rensselaer 47978
Jefferson-Switzerland	Robert Mulford, Versailles	Joseph F. Vormohr, 604 W. Arch St., Portland 47371
Jennings	James L. Calli, North Vernon	Ott B. McAtee, Madison State Hospital, Madison
Johnson	Steven A. Weber, Franklin	F. Richard Walton, 311 Henry St., North Vernon 47265
Knox	Frederick H. Buehl, Vincennes	Chandrabhan Singh, Johnson Co. Memorial Hospital, Franklin 46131
Kosciusko	David W. Haines, Warsaw	Phillip B. Kinman, 609 Dubois St., Vincennes 47591
LaGrange	Millard R. Taylor, Howe	George A. Ros, 827 S. Union St., Warsaw 46580
Lake	Thomas A. Gehring, Merrillville	Evan C. Thompson, P.O. Box 217, Topeka 46571
LaPorte	Barbara Backer, LaPorte	Mary E. Carroll, 124 N. Main St., Crown Point 46307
Lawrence	Gerald E. Kasting, Bedford	Mr. John B. Twyman, Ex. Dir., 6685 Broadway, Merrillville 46410
Madison	Kenneth E. Schemmer, Anderson	Robert M. Kelsey, 1200 Michigan Ave., LaPorte 46350
Marion	George T. Lukemeyer, Indianapolis	Orville A. Schumm, Exec. Dir., 110 South Ave., La Porte 46350
Marshall	Michael F. Deery, Culver	Gareth A. Morgan, 1618—24th St., Bedford 47421
Miami	Maurice Sixbey, Denver	John D. Jones, 1719 N. Madison Ave., Anderson 46012
Montgomery	Fred P. Warbinton, Crawfordsville	George H. Rawls, 3151 N. Illinois St., Indianapolis 46208
Morgan	O. R. Wilson, Morgantown	Mr. Harold W. Hefner, Exec. Dir., 211 N. Delaware St., Indianapolis 46204
Newton	R. S. Jardenil, Kentland	Byron Holm, 304 N. Walnut, Plymouth 46563
Noble	John E. Ramsey, Kendallville	A. L. Baluyut, 29 E. Main, Peru 46970
Orange	Charles X. McCalla, Paoli	Jack L. Foltz, 1407 Darlington Ave., Crawfordsville 47933
Owen-Monroe	William R. Anderson, Bloomington	Stephen L. Hardin, 171 E. Washington St., Martinville 46151
Parke-Vermillion	George Alexandrescu, Clinton	E. L. Gamba, Lake Village 46349
Perry	Robert Gilbert, Tell City	Carl F. Stallman, R.R. 3, Kendallville 46755
Pike	Donald L. Hall, Petersburg	Philip T. Hodgins, Orleans
Porter	James R. Brown, Valparaiso	Mark Wisen, 619 W. First, Bloomington 47401
Posey	Harold E. Ropp, New Harmony	Arlene Rhea, Exec. Secy, 1920 E. Third St., Bloomington 47401
Pulaski	Harold J. Halleck, Winamac	J. Franklin Swaim, P.O. Box 185, Rockville 47872
Putnam	Fred Haggerty, Greencastle	Robert A. Ward, Professional Bldg., Tell City
Randolph	Jerome M. Leahy, Union City	Donald L. Hall, 7th and Poplar, Petersburg 47567
Ripley	Manuel G. Garcia, Batesville	Uldarico B. Blando, 802 LaPorte Ave., Valparaiso 46383
Rush	Davis W. Ellis, Rushville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
St. Joseph	Richard Schaphorst, Mishawaka	William R. Thompson, 111 N. Monticello St., Winamac 46996
Scott	Benjamin V. Roberto, Austin	F. R. Dettloff, 407 Melrose Ave., Greencastle 46135
Shelby	Lucian A. Arata, Shelbyville	C. R. Miranda, 702 Browne St., Winchester 47394
Spencer	Michael O. Monar, Rockport	Thomas E. LeBeau, Margaret Mary Hospital, Batesville 47006
Starke	Walter Fritz, Knox	Harry G. McKee, 208 W. First St., Rushville 46173
Steuben	Donald Mason, Angola	Richard Buck, 51916 U.S. 31 North, South Bend 46615
Sullivan	John R. Taylor, Palestine	Mrs. Rose Vance, Exec. Secy., 2015 Western Ave., South Bend 46629
Tippecanoe	Altamont Bracey, Lafayette	Manuel T. Dancel, 675 N. Gardner St., Scottsburg 47170
Tipton	Destroy W. Lambert, Tipton	Dar Muceno, 103 W. Washington, Shelbyville 46176
Vanderburgh	Wallace M. Adye, Evansville	John C. Glackman, Jr., Rockport
Vigo	Tom J. Conway, Terre Haute	Earl Leinbach, Hamlet
Wabash	Charles R. Lyons, Wabash	K. L. Kissinger, 411 E. Eilmere St., Angola 46703
Warrick	Robert H. Terry, Boonville	Joe Dukes, South Third St., Dugger 47848
Washington	Charles B. Carty, Pekin	Robert Williamson, c/o 2424 Ferry St., Lafayette 47904
Wayne-Union	William R. Stilwell, Richmond	George L. Compton, 219 N. Independence, Tipton 46072
Wells	Louis F. Bradley, Bluffton	Mrs. Carole Rust, Exec. Dir., 421 N. Main St., Evansville 47711
White	Max L. Fields, Monticello	James W. Cristee, 400 8th Ave., Terre Haute 47804
Whitley	Claude J. Heritier, Columbia City	William L. Purcell, Exec. Secy., P.O. Box 986, Terre Haute
		Parks M. Adams, Jr., 1103 N. Wayne St., N. Manchester 46962
		Carlos M. Ruiz, 123 S. Second St., Boonville 47601
		Thomas R. Northcott, 102 N. Harrison, Salem 47167
		Richard M. Butler, Reid Memorial Hospital, Richmond 47374
		James E. Umphrey, 303 S. Main St., Bluffton 46714
		Nolan A. Hibner, 222 S. Main St., Monticello 47960
		John Vogel, 215 E. Van Buren, Columbia City 46725



"Efficiency is the key to your practice"
 Graduates of P. C. I. are thoroughly trained
 in the most up-to-date methods as Medical
 Assistants (AMA accredited) and Medical
 Receptionists.

PROFESSIONAL CAREERS INSTITUTE

6321 La Pas Trail, Indianapolis, IN 46268
 Telephone: (317) 299-6001

Are You Moving?

If so, please send change of address to Membership
 Dept., ISMA, 3935 N. Meridian St., Indianapolis, IN
 46208, at least six weeks before you move.

Name _____

Address _____

City _____ State _____ Zip _____

County _____

IMPORTANT — Attach mailing label from your last
 Journal here.

ADVERTISERS IN THIS ISSUE

August 1978

Vol. 71

No. 8

Blue Cross-Blue Shield	727
Bristol Laboratories	746,747
Brown Pharmaceutical Company, Inc.	755
Burroughs Wellcome Co.	784
Campbell Laboratories, Inc.	738
Flesher, Realtor	788
General Microcomputer, Inc.	745
Giganti, Inc.	798
Hanger Prostheses	787
Indiana Medical Bureau	789
Lilly, Eli and Company, Inc.	729
McClain Car Leasing, Inc.	779
Mead Johnson Laboratories	749,750
Medical Protective Company	797
Morris Plan	740
P&SLI	786
Professional Careers Institute	800
Roche Laboratories	Covers
Rockwood Insurance Company	739
Smith, Kline & French	736-737, 783
S-Tek Computer Services, Inc.	740
The Upjohn Company	743
Yellow Medi-Car	792

In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

September 1978 • Vol. 71 • No. 9

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION


Indiana State Medical Association Journal

The Library, Acquisitions Dept.
U. of Calif., San Francisco
SAN FRANCISCO, CA 94143

LIBRARY
U.C. SAN FRANCISCO

SEP 21 1978

Convention Issue

A composite image of a human face and a brain diagram. The face is shown in profile, looking down, with a hand near the mouth. The brain diagram is overlaid on the face, showing the cerebral cortex and internal structures.

Anxiety...
Often a significant feature
of irritable bowel syndrome*

The action of
Librium®
(chlordiazepoxide HCl)

A significant advantage
of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

Antianxiety
Antisecretory
Antispasmodic

Librax is unique among OTC medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic action of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.

*Librax has been evaluated as potentially effective for this indication.
Please see full summary of prescribing information on following page.

ROCHE

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

WHAT'S NEW?

Metropolitan Wire Corporation has a new Bedside Emergency Resuscitation Cart built especially for cardiopulmonary emergencies. It may be moved easily at top speed without tipping or scrambling the contents. Maneuvers easily between beds and into tight corners. It unfolds to display up to 14 square feet of medications and supplies.

* * *

Norwich-Eaton Pharmaceuticals has just introduced Duvold® (bethanechol chloride) 50 mg tablets for the treatment of nonobstructive urinary retention and atony of the bladder. The drug was previously available in up to 25 mg strength. Urologists have frequently reported that a minimum single oral dose of 50 mg is usually required for a therapeutic response.

* * *

Fischer is introducing a new portable X-ray system, ideal for clinical and industrial applications where in-the-field radiography is required. It is compact, weighs 52 pounds, and is easy to transport and set up. It uses a standard 120 volt outlet. The tubehead incorporates a light beam collimator to facilitate accurate positioning.

* * *

Bristol is introducing Salutensin-Demi™, a new hypertensive agent. It is a thiazide-reserpine combination. It is introduced to achieve flexibility of dosage in the Salutensin® line of products. Demi (one-half) signifies a reduced amount of thiazide.

* * *

Lloyd Distributors has announced the Rainbo All-Sport Prescription Eyeguard. It allows the user, from novice to professional adult, to participate fully in all athletic endeavors. The Eyeguard frame has an adjustable headband, foam rubber comfort cushion, wide vision wrap-around prescription lens, and the frame is made of a virtually indestructible space-age plastic.

* * *

Picker has a new battery-operated mobile radiography unit. It is cordless and only 23 inches wide. The nickel-cadmium battery pack has power capacity for a full day's exposure caseload. Recharging is fast and a normal 120 Vac outlet is sufficient.

* * *

Searle has announced the introduction of intravenous Norpace (disopyramide phosphate) for clinical use in Australia and New Zealand, the first countries to approve an injectable form of the drug used to treat potentially life-threatening arrhythmias. The intravenous form is expected to be used in hospitalized patients who require rapid resolution of arrhythmia.

* * *

CONTINUED ON PAGE 815

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis



Dr. William Stark, who practices medicine in LaPorte County, provided most of the information for this page. Dr. Stark, who incidentally provided the topic for the first page of notes when this feature commenced in the January 1976 issue of *The Journal*, is interested in the students and graduates of the La-

Porte medical school, more correctly designated as the Indiana Medical College (LaPorte University). He also provided a biographical article, published in the most recent issue of the *Indiana Medical History Quarterly*.^{*} A few facts from that article are reproduced here.

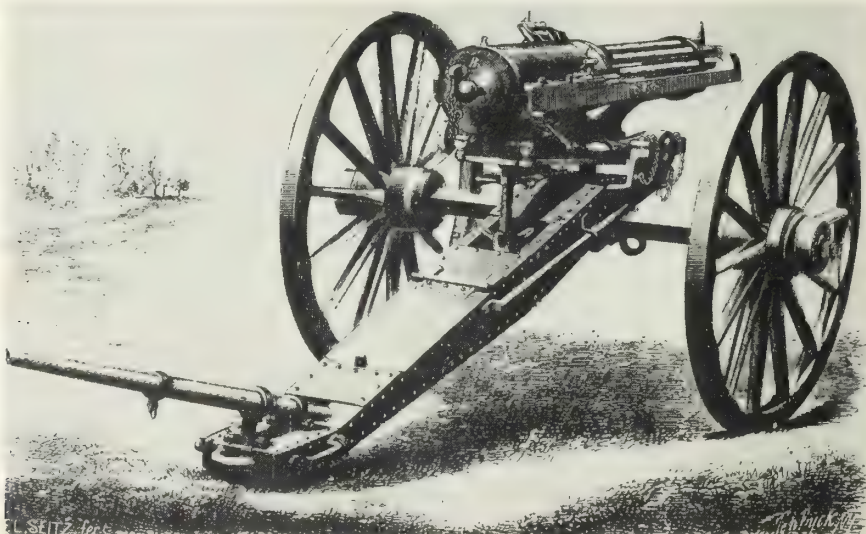
The subject is Dr. Richard J. Gatling. He was a student of the LaPorte school, attending the session of lectures from November 1847 to February 1848. To obtain an M.D. degree, he attended the required second course of lectures at the Ohio Medical College of Cincinnati. Dr. Gatling, whose principal profession was that of inventor, did not study medicine with the intent to practice but rather to insure the health needs of his own family.

Dr. Gatling, inventor of a number of farming devices, is best known for the Gatling gun. This rapid-fire weapon, the world's first such successful device, was test-fired, according to Dr. John MacDougall, Indianapolis surgeon, in central Indiana over White River, probably in 1862. The gun had very limited service in the Civil War but was used extensively by the U.S. Army and in armies abroad after the war.

Dr. Gatling, born in North Carolina in 1818, spent a number of

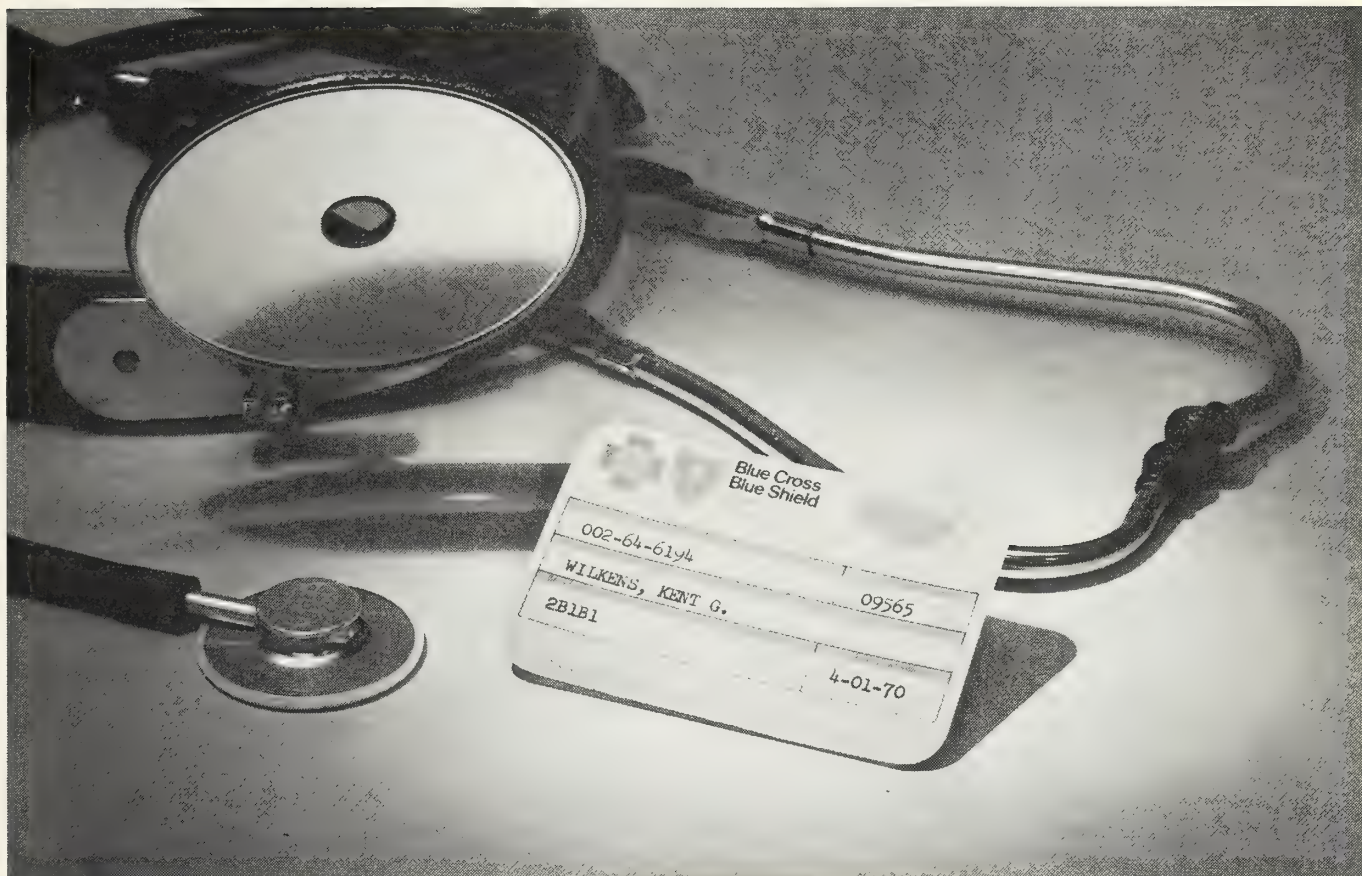
years in Indiana. He married one of the daughters of Dr. John H. Sanders, who became the first president of the Indianapolis Medical Society in 1848 and who presided at the first annual meeting of the Indiana State Medical Society (now the ISMA) until officers were elected in 1850. (Another of Dr. Sander's daughters was married to Governor Wallace thus making Dr. Gatling the uncle by marriage of the Civil War general and author of *Ben-Hur*, Lew Wallace).

Dr. Gatling died in 1903 and is buried in Crown Hill, Indianapolis. When the Educational Resources Program of Indiana University School of Medicine was filming *The Wisest Man in the Valley* (the early history of medicine and medical education in Indiana), footage of the Gatling gun in operation was needed. We wrote letters to the Defense Department and to a number of museums and other sources to see if footage could be obtained or if the Resource's camera crew could photograph the gun in action. Footage was finally located. Among the available options not accepted was the offer of a young man to give us his inherited Gatling gun in exchange for a four-year college education.



* Indiana Historical Society
315 W. Ohio St.,
Indianapolis 46202

Take advantage of a great association!



Get these special benefits — available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage — and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association — entitling you to special group rates for these benefits:

- One full year in-hospital care
- 100% semi-private room and hospital extras
- Allowances for surgery, anesthesia, obstetrics, medical visits, diagnostic and radiation therapy
- \$250,000 Major Medical Benefits

That's not all. You also benefit from the immediate recognition and automatic acceptance of the Blue Cross and Blue Shield membership card. The special rates available through the Indiana State Medical Association membership make this coverage your best investment in personal protection. You can get it — now.

Call or write: Mrs. Kathryn Eads,
Professional Accounts, Blue Cross and Blue
Shield of Indiana, 120 W. Market Street,
Indianapolis, Indiana 46204. Telephone: (317)
263-4925.

120 West Market St.
Indianapolis, Ind. 46204

® Reg. Mark Blue Cross Assn.
® Reg. Serv. Mark. Nat'l Assn.
of Blue Shield Plans



**Blue Cross
Blue Shield**
of Indiana

Contents

SCIENTIFIC ARTICLES

- 831 **Dysfunctional Uterine Bleeding—**
Leo M. Bonaventura, M.D.
(*Ninth Continuing Medical Education article*)
- 835 **Coronary Artery Endarterectomy—**
Harry Siderys, M.D.
- 837 **Thyroid Function Tests—**
Corbin P. Roudebush, M.D.

EDITORIALS

- 807 **Health, Hospital Care Survey Results**
- 808 **Editorial Notes**
- 813 **The Declining U.S. Economy—**
L. A. Arata, M.D.

SPECIAL FEATURES

- 814 **Emergency Medical Council Ready**
- 815 **A Preview: Convention '78**
- 826 **Retirement: Perhaps His Greatest Challenge—**
Harry W. Salon, M.D.
- 865 **Table of Contents: Convention Section**

DEPARTMENTS, MISCELLANEOUS

- 801 **What's New?**
- 802 **Museum Notes—***Charles A. Bonsett, M.D.*
- 820 **Tax Tips—***Lawrence A. Jegen III, J.D.*
- 841 **Royal College of Surgeons of England—**
Malcolm B. Herring, M.D.
- 843 **From The Journal 50 Years Ago**
- 844 **Auxiliary Report—***Mrs. Everett Bickers*
- 847 **Cancer Corner—***William M. Dugan, Jr., M.D.*
- 849 **Future File**
- 855 **Book Reviews**
- 857 **News Notes**
- 861 **As I See It—***David M. Harvey, M.D.*
- 940 **Obituaries**
- 941 **ISMA Officers, Trustees, Delegates**

ABOUT THE COVER

There's always plenty to do "down on the farm" where walking gingerly along the top of a wooden fence has to rank as one of the top sports—at least with the kids. Although the trend these days is toward an urban society, Indiana travelers can't miss those "little red barns"—and some big ones, too—that dot the state. PHOTO COURTESY INDIANA DEPARTMENT OF COMMERCE



EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue.

Representative for national advertising is the State Medical Journal Advertising Bureau, 711 South Blvd., Oak Park, Ill. 60302.

Annual subscription rates: ISMA members, \$8, included in annual membership dues; ISMA senior members, \$10; Libraries, \$12; all others, \$14. Additional postage: Canada and PUAS countries, \$2; Foreign, \$3. Subscriptions are renewable in July and January.

Entered as second class matter January 25, 1933, at the Post-office at Indianapolis, Indiana.

Copyright 1978 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian St., Indianapolis 46208. All material subject to this copyright may be copied for the noncommercial purpose of scientific or educational advancement.

Second class postage paid at Indianapolis, Indiana, and at additional mailing office.

All issues of 1967 and subsequent may be obtained on microfilm. Address The Journal for details.

Our International Standard Serial Number is ISSN 0019-6770.

Indexed in Index Medicus and Hospital Literature Index.



"I USED TO DESIGN RACING CARS. BUT THE AUDI 5000 WAS A BIGGER CHALLENGE."

AN INTERVIEW WITH FERDINAND PIËCH, AUDI 5000 PROJECT DIRECTOR



Sir, how long did you design racing cars?

Piëch: Ten years in all. I brought six cars from the drawing board to the race track and all six went on to win world championships. It was all very exciting.

And you say designing a passenger car was more of a challenge?

Piëch: It was for me. A racing car can be designed to last for a few races only. But a passenger car obviously has to be designed to do much more and to last much longer. In addition to excellent performance and handling I had to consider things like room, comfort and price.

What about the price?

Piëch: I was determined from the beginning to prove that a large German luxury sedan could be produced for under \$9,000.*

Well, you succeeded with price, but did that mean you had to compromise a lot?

Piëch: No. I don't think so. It was a question of eliminating unnecessary things. The greatest example of that is our five-cylinder engine. Five cylinders, because a four was too small for the weight of the car, and a six was too extreme. Designing the perfect engine for the vehicle can hardly be called making a compromise.

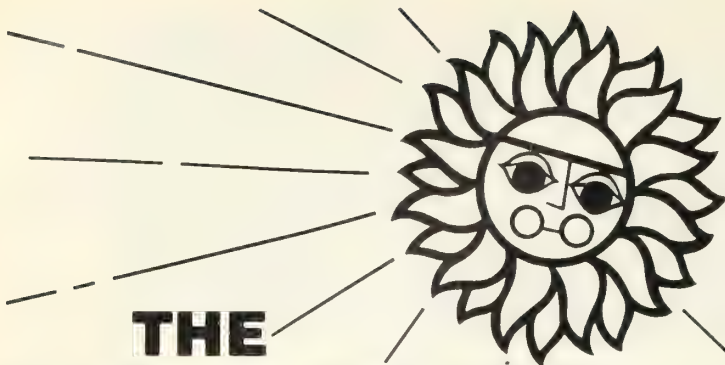
Your racing background? Did it come in handy?

Piëch: Yes. Very much so. The way the Audi 5000 handles, for instance. The ride is not in the least bit mushy. Our suspension, rack-and-pinion steering and weight distribution have a lot to do with that. Some people feel that a soft, mushy ride is luxurious. We do not. We think it's tiring because you seem to be correcting the car's handling so often. That's why we suggest that people pick a rainy or snowy day for a test drive. This car is at its best when the weather is at its worst.

*Suggested 1978 retail price \$8,780, P.O.E. transp., local taxes, and dealer delivery charges, additional

See your nearby Audi dealer.





THE MARION COUNTY MEDICAL SOCIETY

extends a special invitation to
all members of the Indiana
State Medical Association
to join us on trips to:

• **HILTON HEAD**
(November 2-5, 1978)

• **CURACAO**
(January 18-21, 1979)



DON'T DELAY!

HILTON HEAD

Your Program Includes:

- Round trip air transportation from Indianapolis to Savannah, Georgia and return, based on current excursion fare.
- Three (3) nights accommodations at the Sea Pines Plantation based on two (2) persons sharing each one bedroom villa.
- Round trip transfers between Savannah and Sea Pines.
- All taxes and baggage handling.

PROGRAM DATES: November 2-5, 1978

LAND COST PER PERSON: \$151.00

AIR COST PER PERSON: \$125.00

SCHEDULE OF PAYMENTS:

August 1, 1978 — \$125.00

September 20, 1978 — \$151.00

CURACAO

Your Program Includes:

- Round trip air transportation from Indianapolis to Curacao and return, via Miami and return, based on current Group 40 airfare.
- Three (3) nights accommodations at the Curacao Hilton, based on double occupancy.
- Round trip transfers between airport and the Hilton.
- All taxes and baggage handling.

PROGRAM DATES: January 18-21, 1979

LAND COST PER PERSON: \$125.00

AIR COST PER PERSON: \$397.20

SCHEDULE OF PAYMENTS:

September 20, 1978 — \$125.00

December 18, 1978 — \$397.20

PLEASE NOTE: Programs outlined herein are based on tariffs in effect as of June 1, 1978.

RESPONSIBILITY

Group Travel Consultants acts only as Agent in providing means of transportation or other services and all tickets are issued and all other services are offered or provided subject to any and all terms and conditions under which such means of transportation or other services are offered or provided, and the issuance and acceptance of such tickets and other services shall be deemed to be consent to the further condition that Group Travel Consultants shall not be or become liable or responsible in any way in connection with such means of transportation or other services or for any loss, injury or damage to or in respect of any person or property howsoever caused or arising. The airlines concerned are not to be held responsible for any act, omission, or event during the time passengers are not aboard their aircraft. The passenger tickets in use by the carriers when issued shall constitute the sole contract between the airlines and the purchaser of these tickets and/or passenger.

Enclosed please find my deposit/full payment for _____ people,
for Hilton Head [] or Curacao []

NAME _____

ADDRESS _____

PHONE (Home) _____ (Business) _____

CITY _____ STATE _____ ZIP CODE _____

IDENTIFICATION # (Driver's License, etc.) _____

Please make checks payable to **GROUP TRAVEL CONSULTANTS**

Return Checks To: **Marion County Medical Society**

Hilton Head #3780066

Curacao #3790010

211 North Delaware
Indianapolis, Indiana 46204
(317) 639-3406

EDITORIALS

Health, Hospital Care Survey Results

"Hospital Care in America" is the title of a national opinion research survey of health and hospital care conducted in the early months of 1978. Content of the study was developed by the Yale Department of Epidemiology and Public Health. The interviews were done by Louis Harris & Associates. Chosen to adequately represent the entire population were 1,503 adults, who were interviewed extensively. Additionally, 283 representatives of five leadership groups were surveyed. The groups were members of Congress, doctors, hospital administrators and trustees and health insurance executives.

Despite overwhelming public satisfaction with the quality of health care today, 70% of the American public believes that "the health care system is out of control and needs to be changed."

However, the public rejects any "cap" on hospital revenues or increased government regulation of hospitals.

Although 60% of the public wants more money spent on health care, hospital costs were considered to be overpriced as compared with other necessities.

The survey found that the public is (46% to 38%) opposed to government regulation of hospitals, and 85% opposed to regulations that would inhibit the prerogatives of doctors.

The leadership groups were overwhelmingly opposed to price controls as a method of containing hospital costs; the public voted in favor, 50% to 34%.

Louis Harris is quoted as saying, when discussing the survey: "Despite the public's complaints about hospital costs and support for some cost-containing measures, at the individual level the American public wants the best available care and is willing to pay for it."

He said, for example, that the public is "not only reluctant to give up its right to choose a doctor or a

particular hospital in order to help reduce costs, but even unwilling to wait a half hour longer before getting non-emergency care."

The public was found to be in favor of:

- Requiring a second medical opinion before allowing hospitalization or surgery;
- Having minor operations without staying overnight;
- Encouraging insurance companies to negotiate with hospital officials about how much various treatments will cost, rather than paying a set fee;
- Requiring hospitals to make detailed estimates of their future costs and services, and paying them according to these estimates even if their costs and services exceed these estimates; and
- Applying federal anti-trust laws to Blue Cross with respect to its negotiations of discriminatory rates with hospitals.

The public voted 65% to 21% to oppose a cost controlling policy that would result in a reduction in hospital beds.

Hospitals were rated by the respondents on quality and efficiency. Hospitals run by churches were at the top. Public hospitals owned by cities or counties got the lowest marks.

By 38% to 13%, the public feels that unionization of hospital employees is more likely to lower health care standards, and 73% think unionization would make health care more expensive.

On national health insurance:

- 29% favor the present system;
- 36% favor the present system but with changes that would extend health insurance to those not adequately covered; and
- 32% favor national health service.

In general, the 61 Congressmen interviewed expressed opinions that are in opposition to those held by the general public.

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 3935 N. Meridian Street, Indianapolis 46208.

Consulting Editors: A. W. Cavins, M.D., R.R. 25, Box 172, Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1, Box 202, Gaston 47342; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne 46802; I. W. Wilkens, M.D., 4820 E. Pleasant Run Pkwy., N. Dr., Indianapolis 46201; W. D. Snively, Jr., M.D., R.R. 1, Box 227, Evansville 47712; Charles A. Bonsett, M.D., 6133 E. 54th Place, Indianapolis 46226.

Business Manager: Donald F. Foy

3935 N. Meridian, Indianapolis, Ind. 46208

Editorial Board:

Steven C. Beering, M.D., Indianapolis	.....Dec. 31, 1978
Paul S. Rhoads, M.D., Richmond	.....Dec. 31, 1978
Elton Heaton, M.D., Madison	.....Dec. 31, 1979
Rodney A. Mannion, M.D., La Porte	.....Dec. 31, 1979
Alvin J. Haley, M.D., Fort Wayne	.....Dec. 31, 1980
Wei-Ping Loh, M.D., Gary	.....Dec. 31, 1980

Term Expires

Managing Editor: Martin T. Badger

Health, Hospital Care Survey Results

The survey found that there is no consensus on the meaning of "National Health Insurance."

Twenty-seven per cent of doctors feel that they are overpaid as opposed to 66% who feel they are paid about right. Sixty-six per cent of the public think doctors are overpaid.

The survey presents all the indications that it has been carefully devised and that it has been executed in a scientific manner. The results should be reliable. Everyone concerned in any way with the problem of cost containment should have access to the full report. Hospital Affiliates International, responsible for initiating the study, is to be congratulated for the accomplishment.

Editorial Notes . . .

You hear a lot from adults who can't open a child-proof aspirin bottle, but the good news is that aspirin poisonings in children have dropped from first to fourth place on the list of causes of poisonings among children age 5 and under. According to the I.U. Institute for Research in Public Safety, first place is now occupied by house plants—dieffenbachia, holly berries, pyrocantha (firethorn), poinsettia, pokeweed, woody nightshade, African violet, Jerusalem cherry, black elder and begonia. Other children's poisons are soaps, detergents and cleaners (second place), while vitamins and minerals are ranked third, and antihistamines and cold medicines take fifth place.

The Metropolitan Life Insurance Company "Statistical Bulletin" recognizes the Health Maintenance Organization as a means of cost control during a period of rapidly rising health care costs. Modern top-drawer full-coverage medical care is so expensive only a few of the very rich can afford it. Some means must be found to determine how much medical care is necessary—and affordable. The HMO, with its prepaid feature, will give the answer. If the answer is no, then some other means of rationing medical care must be found.

Prostacyclin is a member of the prostaglandin group. It was discovered in 1976 and its chemical structure has been determined. Upjohn researchers are now working with analogs of prostacyclin, which show promise of being useful in treatment of cardiovascular disease. The new compounds appear to play a protective role in blood vessels by maintaining a balance between normal blood flow and the clotting of blood required to control bleeding.

The Du Pont Company has established a new category of educational aid grants in toxicology to encourage increased research into the effect of chemicals on the human body. \$140,000 has been designated for such assistance this year. This is in addition to the company's multi-million dollar aid-to-education program. Most of the new grants will go to graduate students or post-doctoral fellows.

PEDIATRICS reports the results of a study involving the cost of treatment of 75 infants who weighed 2.2 pounds or less at birth. The in-hospital costs are reported as follows: The average daily cost for the 45 infants who died within 1 to 165 days was \$825 per infant. The average daily cost for surviving infants was approximately \$450. The average cost of insuring that a premature infant will leave the hospital healthy and "normal" is \$115,356, a figure calculated in September 1976. Costs have risen 31% since then.

A research report from Johns Hopkins University in the July 28 issue of JAMA confirms that there is no association between total artificial sweetener use and bladder cancer in humans. A group of 519 individuals with confirmed diagnoses of bladder cancer and an equal number of matching controls were interviewed concerning use of artificial sweeteners and other environmental factors. Exposure to artificially sweetened beverages of all kinds was about the same in patients and in controls, of both sexes.

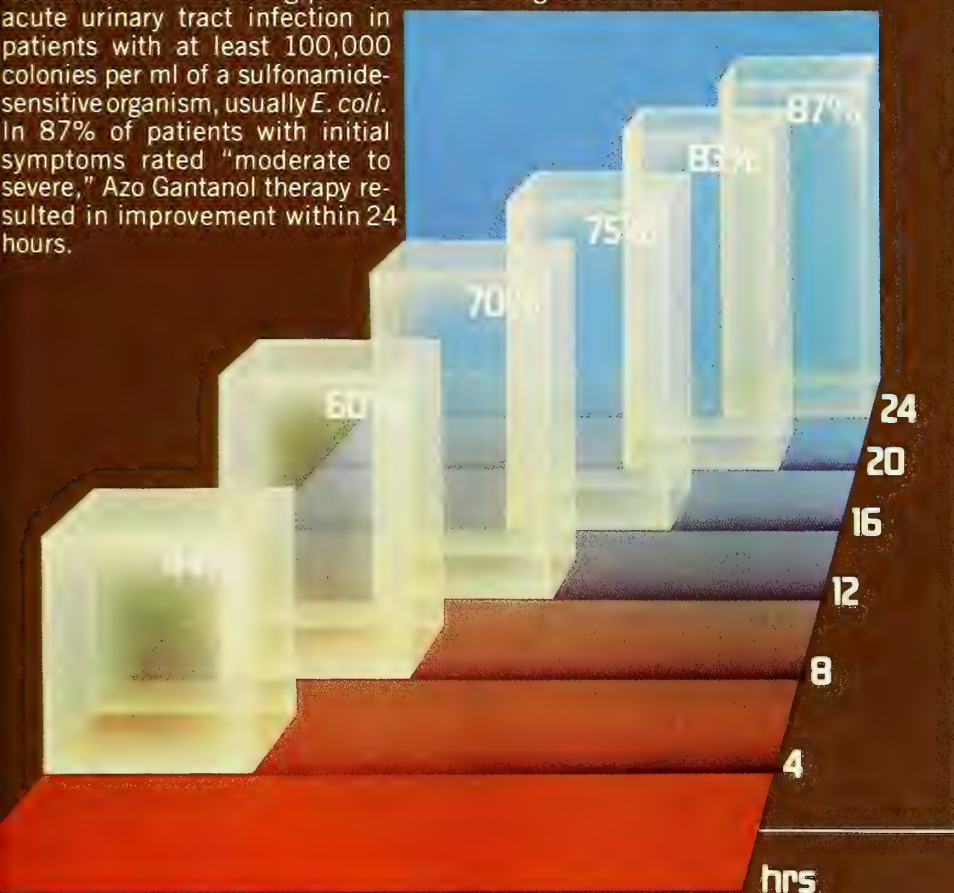
The AMA has filed suit against the Federal Trade Commission in an effort to overturn the FTC's ruling on advertising of ophthalmologists' and optometrists' services. At issue is whether a federal administrative agency has the legal right to invalidate a law passed by a state legislature. The FTC ruling prohibits states from having laws that bar the advertising of eyeglass prices; it requires ophthalmologists and optometrists to give patients copies of their eye prescriptions. The AMA suit argues that state legislatures should be permitted to pass laws governing competition and medical practice, as long as they are reasonable and constitutional.

The National Society for Medical Research reports that laboratory tests for industrial chemical and water-borne pollutants may now be done in less than a week in contrast to older methods, which required two years. The difference is the laboratory animal. Formerly, tests for mutagenic and carcinogenic effects were performed on rodents. The new method makes use of the mudminnow, a small, olive-colored fish that usually resides in slow-moving, mud-bottom streams.

Important data on the pain of acute cystitis:

In 87% of patients studied (303 of 349), Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for
the pain

for
the pathogens

Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.


Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Tagamet®

brand of
cimetidine

How Supplied: Pale green, 300 mg, tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).

Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
a SmithKline company

Sore throat-

the most common complaint you'll see this winter?

CĒPASTAT®

mouthwash/gargle and lozenges

relief of minor sore throat
when patients want it... *stat*

In pharyngitis and tonsillitis, prompt temporary relief of pain is possible even before patients leave your office...

Proven Anesthetic Effectiveness

The well-established topical effects of phenol in CĒPASTAT Products, provide soothing temporary anesthesia to the irritated or inflamed oropharyngeal mucosa. Relief occurs in minutes... the end of relief especially appreciated by patients waiting for anti-infective measures to take hold.

In two advanced formulations

CĒPASTAT mouthwash/gargle (and spray) blends eugenol with phenol to provide a new authoritative flavor that tells your patients relief from discomfort is at hand.

CĒPASTAT sore throat lozenges combine menthol with phenol to provide a desirable cooling action and anesthesia. These active ingredients are in a smooth-tasting sugar-free sorbitol base. The result: temporary relief and a smooth, comfortable taste.

CĒPASTAT Products are now available for your recommendation at pharmacies everywhere.



From the
makers of
Cēpacol® Products

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



EMPIRIN[®] COMPOUND c CODEINE

Each tablet contains: aspirin, 227 mg; phenacetin, 162 mg; and caffeine, 32 mg; plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1); #3—30 mg (gr ½); #2—15 mg (gr ¼); and #1—7.5 mg (gr ⅛). (Warning—may be habit-forming).



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Guest Editorial

The Declining U.S. Economy

L. A. ARATA, M.D.
Shelbyville

Our U.S.A. is considered by most of the world to be a rich country, and we are propagandized to share our wealth with the less-developed nations of the earth. This is supposed to help them. I question this commonly held belief.

The wealth of an individual is the balance between production and consumption of commodities. One must take into consideration gifts and inheritances. Most of us have seen individuals who were destroyed or harmed by gifts and inheritances. Too often, the "easy come easy go" spirit exists.

The wealth of a country or nation is likewise the balance between its production and consumption. If no production exists, there is no wealth. If consumption exceeds production, there is a decrease in total wealth. This seems to be true on both an individual and national level. If poor countries really exist, it would seem that their altering such status must lie in their own successful efforts to increase production. Gifts should be limited to temporary supplementation while they get down to the serious business of self help—lest they do to nations what they so often do to individuals, i.e., harm rather than help.

This essay is prompted by my having traveled to several "poor" countries in Latin America. There I visited countries with vast land resources, vast mineral and other natural resources, and vast people resources. The natural resources lay in their pristine original unused conditions; the land resources remain untilled and unused; the people resources are idle and unemployed; poverty exists; production is near zero. Sending large gifts of commodities to these countries does not increase production nor does it help the people to help themselves.

In looking for the reasons why the resources of

these countries seem so unused, I get the impression that the culprit is government policies that discourage use of the resources. Land resources may be owned by individuals with enough wealth that they need not develop the natural resources. Giving hand-outs to the people does not alter this basic situation. Meanwhile, the local governments do nothing.

I see a strange parallel here to what is happening in our own country. Large resources of coal go untapped and unshipped, while we become increasingly dependent on imported oil. Large people resources are encouraged to life-long idleness by a welfare system that penalizes the productive worker to support them. The progressive income tax further penalizes the productive people from whom the material products flow.

Any attempt to increase production of wealth is hindered by government regulation, the ecology freaks and by interminable litigation in the courts. Government policies causing our national inflation are reducing our productive middle class to poverty at an accelerating pace. Our productive farmers are being forced out of production by land costs and production costs that are out of line with the prices they receive for their bounteous harvests. The extremely wealthy in our nation are able to care for self and to protect self with their own wealth.

As our national over-all production declines, our national total wealth declines. When it declines to the level of our unfortunate Latin American neighbors, we will collectively be in their situation. If we look to the South, we can see our nation's situation, and our citizen's situation as it will surely exist in another generation. It appears inevitable.

Emergency Medical Council Ready To Act in Central Indiana

Bolstered by a \$300,000 one-year federal grant, the young Central Indiana Emergency Medical Services (EMS) council has embarked on a program to analyze and strengthen the delivery of emergency health care to Hoosiers in the metropolitan eight-county area.

The council is a voluntary, not-for-profit coalition of health care professionals and consumers who are concerned about the development of an efficient emergency medical services system in Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan and Shelby counties. (Each county has elected representatives who comprise the EMS board of directors.)

The EMS group includes representatives of the 14 hospitals in the area that have emergency rooms, public safety personnel, physicians, ambulance providers and spokesmen for various consumer groups.

"We have been in the planning stage for several months," said executive director David R. Flynn, "but we could not begin program implementation until we were assured of funding by the Department of Health, Education and Welfare."

A 40-member board of directors, headed by William T. Habig, assistant administrator of St. Vincent Hospital in Indianapolis, is currently studying the efficiency of EMS services in the region and will be preparing recommendations for local government units and others to improve the system.

"We need to make clear the fact that the council has no authority to mandate changes," said Flynn. "We are simply trying to draw together all the people and institutions who are interested in developing a comprehensive regional system and to work cooperatively toward that end."

Additional grants from HEW may be forthcoming, Flynn indicated, if the council can show satisfactory progress.

The council's 220 members are divided into committees which are studying all the components of a smooth-working EMS system—such factors as manpower and training, communications capabilities, transportation, facilities, avail-

ability of critical care units, cooperation of public safety personnel, and consumer participation. In addition, EMS councils have been formed in each of the eight counties to work more specifically on local problems.

Flynn, who formerly directed training for the Indiana Emergency Medical Services Commission, said the council recently surveyed some 350 "opinion leaders" in the eight-county area for their impressions of EMS capabilities.

"The survey results were about what we expected," said Flynn. "Most people believe the system is better than it actually is and that it is capable of dealing with virtually any emergency. The truth is that there are holes in the system, and the council wants to point out where those are and how they can be remedied."

The council has learned, for example, that 49% of the personnel affiliated with ambulance providers in the region have not yet completed the minimum requirements for certification by the state commission.

Many of the ambulances operating in the region, he said, do not yet have the capability of radio traffic with a new UHF communications control center housed at Wishard Memorial Hospital in Indianapolis. In addition, several hospitals in the region are not yet tied into the radio network.

In addition, Flynn said, 44% of the ambulances used in the area do not meet minimum specifications recommended by the Department of Transportation and the General Services Administration. One-fourth of the available ambulances are more than six years old and are costly to maintain.

"We hope that local communities will not rush into new transportation and communications purchases which may later prove incompatible with the rest of the region," Flynn said.

Flynn said the council is developing plans to provide training programs for ambulance personnel and cardiopulmonary resuscitation courses for the general public. Development of a regional communications program also is a major priority of the council.

The offices of the council staff will be located at 3921 N. Meridian, Indianapolis 46208.

WHAT'S NEW?

CONTINUED FROM PAGE 801

Learn Incorporated has published a Medical Edition of its Speed Learning program to help physicians increase reading speed and their comprehension of medical and technical materials. The course is a self-study program that makes use of audio-cassettes in conjunction with printed materials. Especially adapted for physicians who have an abundance of reading to do and little time for doing it.

* * *

DeVilbiss has announced the DeVo₂ Oxygen Concentrator for home use. It provides a continuous source of oxygen for respiratory patients needing low-flow therapy. The DeVo₂ draws in room air, separates nitrogen and oxygen and provides oxygen concentrations varying from 54% to 94%.

* * *

The DeVilbiss DeVo₂ Oxygen Concentrate is now supported by a comprehensive audio-visual program, consisting of 58 color slides, a cassette tape and an easy-to-follow script booklet. The program is designed for the instruction of patients, physicians and technicians. It is available from authorized DeVo₂ dealers at a cost of \$75.

* * *

IN BOOKS . . .

The Technomic Publishing Company has announced a new book that provides sex counselling information. "The Health Practitioner in Family Relationships: Sexual and Marital Issues" provides a concise, up-to-date guide to sexual function and dysfunction. 143 pages—\$15.

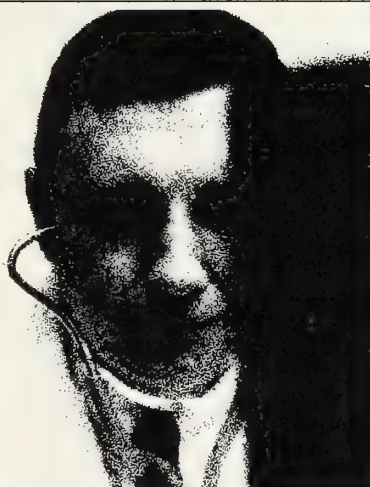
* * *

"Teach'em, Inc." has published a book called "Hospital Regulation through State Rate Review: Mandated Interference or a Noble Intrusion?" which gives the opinions of hospital administrators on both the pro and con sides of the question. 116 pages—\$7.90 with discounts for quantity orders.

* * *

HLS Press has released "Living with High Blood Pressure—The Hypertension Diet." The authors are James C. Hunt, M.D., chairman of the Department of Medicine at the Mayo Clinic, and Joyce Margie, M.S., a nutritionist. The book is available only from the publisher. Send check for \$12.95 to HLS Press, 1455 Board St., Bloomfield, N.J. 07003.

* * *



MALPRACTICE INSURANCE AVAILABLE

Owned by
PHYSICIANS

Operated by
PHYSICIANS

For the protection of
PHYSICIANS

R&S LI

Physicians & Surgeons Liability Insurance Co., Inc.
800 MacArthur Boulevard / Munster, Indiana 46321
219 836-2288

A Preview

CONVENTION '78.....



THE ANNUAL CONVENTION is an opportunity for ISMA physicians and their families to combine business with pleasure. This year the scene will unfold Oct. 22-25 in Clarksville at the Marriott Inn, a 45-acre resort just off I-65 north of Louisville.

As usual, the convention promises to be a worthwhile and meaningful experience for everyone who attends. Highlight of the convention, of course, is the final meeting of the House of Delegates—the legislative and policy-making body of organized medicine in Indiana—on Wednesday, Oct. 25.

During the preceding days, however, the Marriott Inn will host a series of ISMA preparatory meetings, both business and social in nature. Sunday, Oct. 22, for example, will see meetings of the Executive Committee, the Board of Trustees, THE JOURNAL's Editorial Board, three section meetings, the first House of Delegates meeting and five reference committee meetings. Need we say more? It'll be hectic!

Nevertheless, there will be plenty of extracurricular activities to offset the tedium of business meetings, stuffy rooms and hard chairs. Several commercial firms will be present with their exhibits, and there'll be a variety of recreational, sight-seeing and culinary possibilities as well.

Besides the excellent dining facilities and night-

ly entertainment, the Marriott offers a Sports Center that features eight indoor tennis courts and a complete health club. There is an 18-hole miniature golf course on the property, with a regulation course nearby. They have paddleboats and fishing, a handball/squash court, basketball and volleyball courts, indoor and outdoor swimming pools, a picnic area and a sand beach area alongside Lake Marriott.

And then there's Louisville, home of the Kentucky Derby, a zoological garden, yesteryear homes, boutiques, museums, a planetarium, art, ballet, a world-famous symphony orchestra, plays, musicals, bluegrass, jazz, golf, tennis, baseball, bourbon—and boats.

One of the boats, the Belle of Louisville, has been reserved for the conventioners for Monday evening, Oct. 23. Plans call for dinner, dancing, entertainment and liquid refreshments aboard the Belle, the last authentic sternwheel steamboat in America.

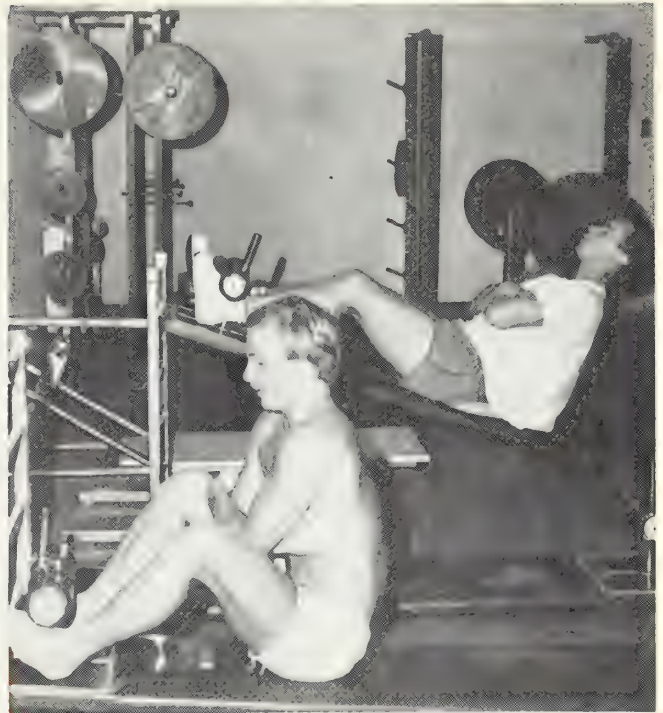
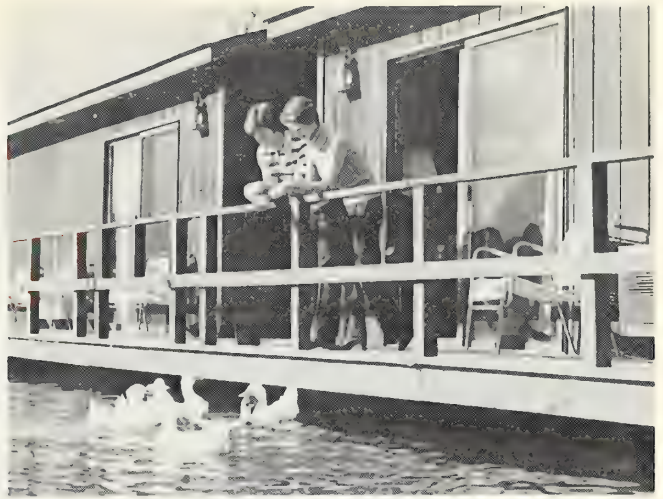
But let's not mislead anyone. The 1978 convention is not intended to be simply a time for wine and song. The issues facing organized medicine are tough ones, and they require the immediate attention of every concerned physician. Decisions that will be made in Clarksville next month could have a far-reaching impact for years to come. Plan to attend!

ISMA ANNUAL MEETING

October 22-25 · Clarksville

... Relaxation

A Time for Work

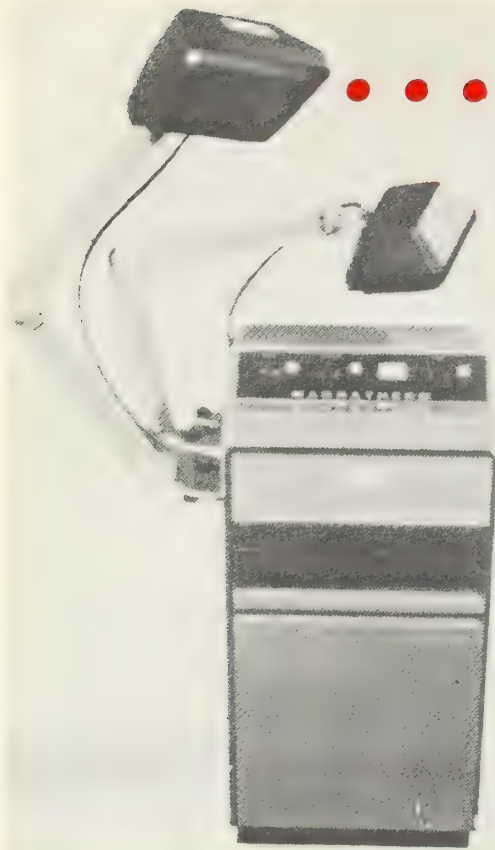


... Exercise

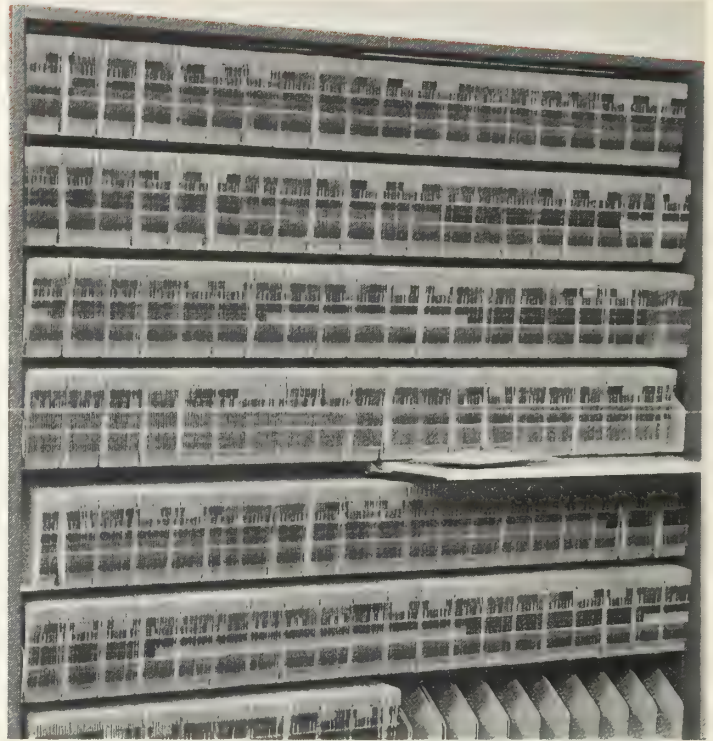
Good Food and Entertainment ...



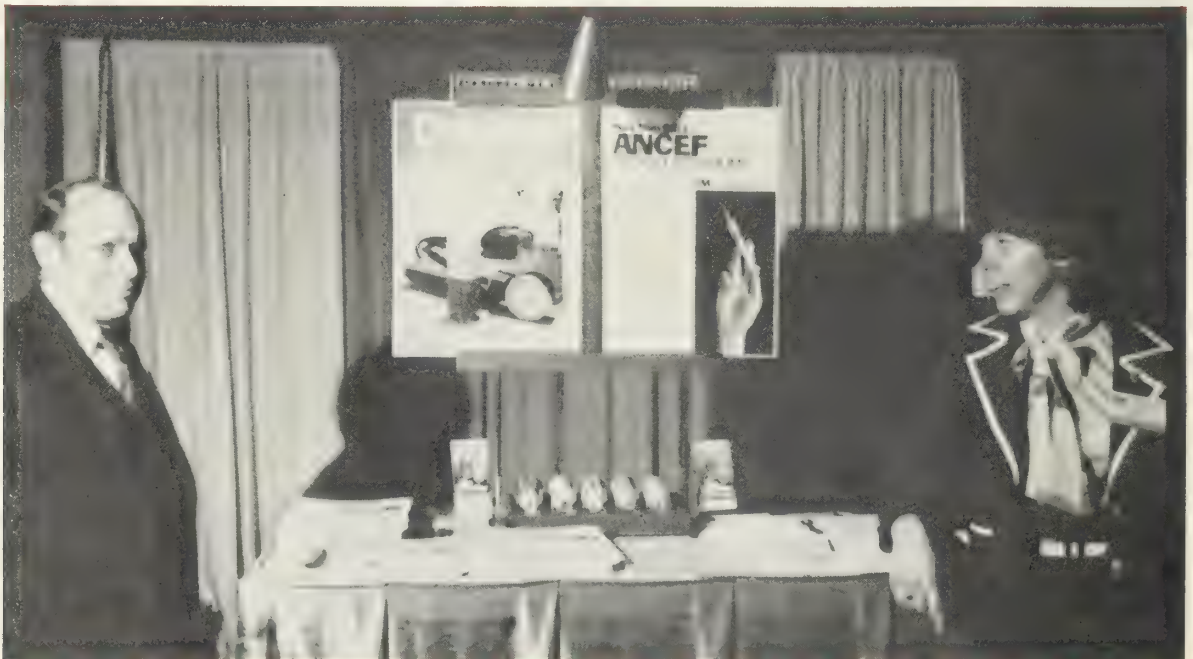
... And Exhibits, Too



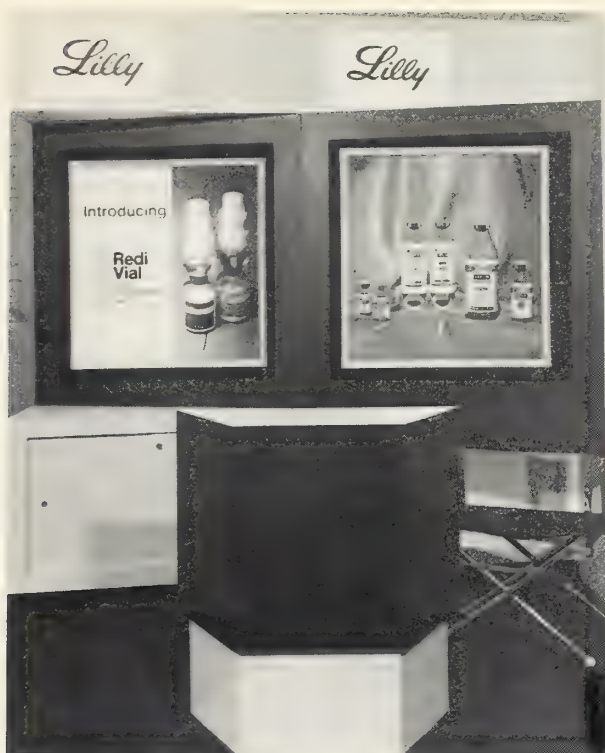
MAGNATHERM, offered by International Medical Electronics, Ltd., of Kansas City, Mo., is a therapy unit featuring detachable treatment heads, an easy-to-read pulse/power scope, solid state digital time counter, and portability.



The **TAB Patient Record Filing System**—TAB has five Indiana offices—advertises the ability to triple floor space capacity, provide alphabetic or numeric filing, eliminate misfiling and speed retrieval time for patient charts.



Smith, Kline and French Laboratories' display will offer physicians a variety of information about their pharmaceutical products. The Philadelphia firm is a regular advertiser in *The Journal*.



CONVENTION '78

For the first time in three years, the annual convention will feature many exhibits from across the country. Technical exhibits (some of which appear on these pages) will be set up by 27 companies—and about a dozen scientific exhibits are expected. A listing of exhibitors, current at press time, appears on Pages 933 to 937.

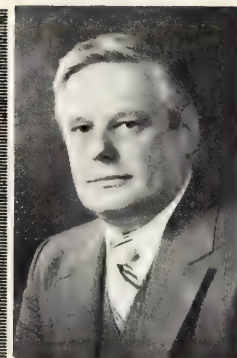
Financial contributions have been received by ISMA from the following firms to assist with the educational program at the 1978 convention:

- Mead Johnson Nutritional Division and Mead Johnson Pharmaceutical Division;
- Parke Davis & Company;
- A. H. Robins Company;
- The Upjohn Company.

Eli Lilly and Company, an Indianapolis pharmaceutical firm that advertises regularly in *The Journal*, will be among dozens of exhibitors at the 1978 convention in October.



Encyclopaedia Britannica will offer this booth at the Clarksville convention site.



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article continues my discussion of the gift and estate tax sections of the Tax Reform Act of 1976 (TRA) and the proposed changes in the Technical Corrections Bill (TCA).

In this article, I shall discuss the only estate tax deduction added by the TRA, namely, the deduction authorized by new section 2057 for transfers to certain minor children. In general, section 2057 provides that a decedent may deduct from the decedent's adjusted gross estate in arriving at the decedent's taxable estate, certain transfers to a natural or a legally adopted child of the decedent, which child has not reached 21 at the time of the decedent's death.

Specifically, a decedent may transfer (and deduct) any amount up to \$5,000 multiplied by the number of years which the particular child is under the age of 21 at the time of the decedent's death. Thus, if all other conditions are met, a decedent may, for example, devise and deduct up to \$50,000 to a child of the decedent, if the child were 11 at the time of the decedent's death (21 less 11 equals 10, and 10 times \$5,000 equals \$50,000).

For a transfer to be eligible for the deduction, the child must be a natural or legally adopted child of the decedent. In addition, there must be no surviving spouse of the decedent—even though the surviving spouse is not a parent of the child. Thus, no deduction will be allowed for a transfer to a minor child if the decedent could have taken an estate tax marital deduction. Further, no deduction will be allowed for a transfer to a natural child of the decedent if the child's other parent is known to have survived the decedent's death and even if the decedent and the other parent are not married at the death of the decedent. On the other hand, if the child is an adopted child of the decedent, then (assuming the other conditions are met, for example, no surviving spouse of the decedent) the deduction may be taken even though one or both of the child's natural parents survive the decedent.

There are many similarities between the requirements of section 2057 (concerning the estate tax minor's deduction) and section 2056 (concerning the estate tax marital deduction).

First, the property transferred may be either cash or other property.

Second, the property may pass to the minor (or spouse) either before or after the decedent's death, so long as the property (or appropriate interest therein) is includible in the decedent's gross estate, for estate tax purposes. For example, both the

estate marital deduction and the transfer to a minor child deduction may be taken for a transfer of property during the decedent's life, includible in the decedent's gross estate under section 2035 (concerning gifts which are made within three years of the decedent's death).

Third, in general, the deduction for transfers to minors will be allowed only to the extent that a deduction would have been allowable under section 2056(b) if such interest had passed to a surviving spouse of the decedent. Among other things, section 2056(b) provides that no estate tax marital deduction will be allowed for transfers (to the decedent's spouse) of certain terminable interests. However, section 2057 (as this section was initially enacted by the TRA) does permit one type of terminable interest to be transferred to a minor child, which terminable interest will not qualify under section 2056 for the estate tax marital deduction. That is, a decedent may provide that the child's interest (in the property which is devised to the child) may terminate (and the property pass to another person) if the child dies prior to the time when the youngest child of the decedent attains the age of 21.

Because of the limitation described in the preceding paragraph, most devised to minor children (drafted during 1977) devised funds either directly to each minor child or to a trust which provided separate shares for each minor child. And, because the terms of the trust agreement must be the same as those terms which would qualify transfers to the trust for the estate tax marital deduction (if the estate tax marital deduction were involved), with the one terminable interest exception which is stated above, many 1977 trust agreements granted the minor child the net income from the trust and a general power of appointment over the entire trust estate. The latter terms are, of course, permissible exceptions to the section 2056 terminable interest rule, and are terms which are commonly provided in the typical Trust A of the estate tax marital deduction trust arrangement. Thus, in its present form, section 2057 does not allow estate tax deductions for transfers to the typical sprinkle-spray trust.

However, the TCA proposes significant changes to section 2057. The principal changes are directed to the fact that section 2057, as it is presently worded, does not allow deductions for transfers to a trust established for the benefit of more than one minor who and which does not have separate shares (or separate trusts) for the minors.

Because the Report of the House Ways and Means Committee is an excellent and concise explanation of the proposed amendments to section 2057, I shall insert a portion of the Committee's comments:

"The bill amends the provision relating to the orphan's deduction under which property passing to a trust which meets certain requirements, called a qualified minors' trust, qualifies for the orphan's deduction. These requirements relate to (1) the source of the trust corpus, (2) eligible beneficiaries of the trust, (3) restrictions on distributions to beneficiaries, (4) the conditions under which distributions to beneficiaries other than the orphans may be made by the trust prior to its termination, and (5) disposition of the trust property at its termination.

"Under the bill, all of the initial corpus of a qualified minors' trust must be property which passes or has passed from the decedent to the trust. Thus, initial funding of the trust by the decedent's spouse or from third parties is not permitted. For this purpose, the initial corpus of the trust includes any income accumulated by the estate or trust during the administration of the estate.

"All of the beneficiaries who initially have a present interest in the trust must be the decedent's children who have not attained age 21 at the date of the decedent's death. If a child of the decedent is 21 years of age or older on the date of the decedent's death, he cannot initially be a beneficiary with a present interest in the trust. (Such a person, however, may have a future interest in the trust.)

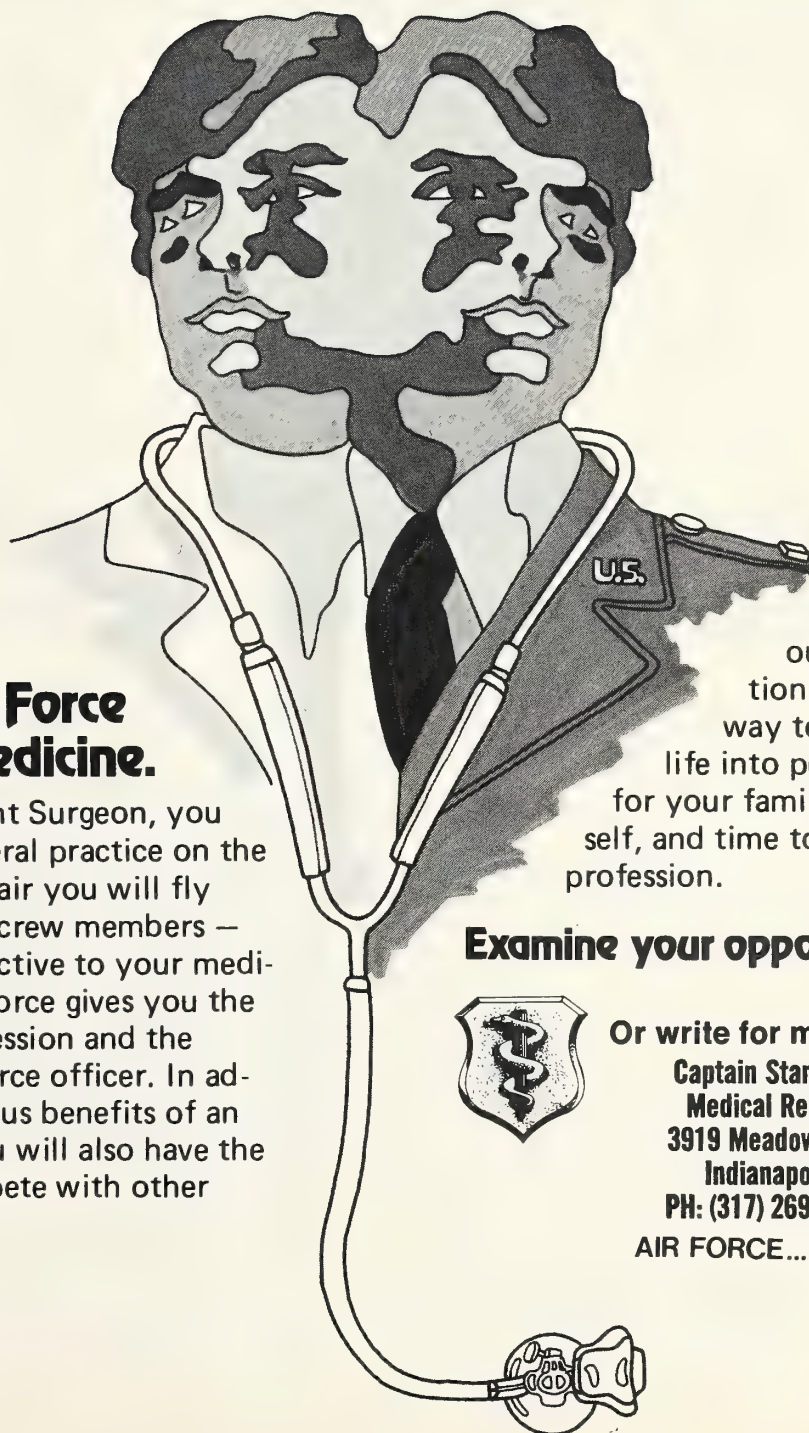
"All distributions to children of the decedent must be made either pro rata to all beneficiaries of the trust or must be made under one or more specified ascertainable standards. The specified ascertainable standards permitted under the bill are standards relating to the health, education, support, or maintenance of the beneficiaries. Under the bill, the ascertainable standard used by the trust may be any, or any combination, of the four specified standards.

"Moreover, under the bill, the trustee may be given absolute or sole discretion to accumulate or distribute the income of the trust (subject to the rules above). Thus, under the bill, it would be permissible to grant the trustee the power to accumulate income or to distribute corpus or income (current and accumulated) to the decedent's children for their health, education, support, or maintenance.

"Distributions prior to the termination of the trust to persons other than the decedent's children may be made only at the

CONTINUED ON PAGE 822

To the physician whose practice needs a new perspective.



Look into Air Force Aerospace Medicine.

As an Air Force Flight Surgeon, you will have a truly general practice on the ground, while in the air you will fly with and observe air crew members — adding a new perspective to your medical career. The Air Force gives you the respect of your profession and the prestige of an Air Force officer. In addition to the numerous benefits of an Air Force career, you will also have the opportunity to compete with other

physicians for an outstanding education program. It's the way to pull your entire life into perspective — time for your family, time for yourself, and time to advance in your profession.

Examine your opportunities now



Or write for more information.

Captain Stanley M. Herndon
Medical Recruiting Office
3919 Meadows Drive, Suite 1
Indianapolis, IN 46205
PH: (317) 269-6624 (COLLECT)

AIR FORCE... A Great Way of Life

TAX TIPS

CONTINUED FROM PAGE 820

death of the children and, in such event, that child's pro rata portion of the trust must be either (1) distributed to any person, (2) vested in a separate share in the trust for any person, or (3) remain in the trust for the benefit of the other surviving minors. For example, upon the death of a child, it would be permissible to provide that the child's pro rata portion of the trust would be distributed to the child's heirs. Likewise, it would be permissible to provide that, in the event of a child's death, his share shall remain in trust as a separate share for the benefit of his heirs. The interest of a child is not to be disqualified because it may pass to another person if the child dies before the youngest child attains age 23. Where the trust instrument does not provide for the distribution or vesting of a child's portion in a separate share of the trust upon his death, that child's portion must remain in the trust for the benefit of the remaining children of the decedent.

"Upon termination of the trust, all of the then corpus and any accumulated income of the trust (other than property in separate shares) must be distributed on a pro rata basis to the children of the decedent living as of the terminating event. The trust need not terminate or vest until the youngest child of the decedent attains age 23."

Now, as to the \$60,000 estate tax exemption of section 2052, it is no longer avail-

able for decedents who die after 1976. This deduction, like all deductions, favored decedents whose estates were in high estate tax brackets over the decedents whose estates were in low estate tax brackets. For example, if a decedent were in the effective 60% state tax bracket, then the \$60,000 exemption could have saved that decedent \$18,000 of estate taxes ($60\% \times \$30,000$). On the other hand, if a decedent were in the effective 40% estate tax bracket, then, the \$60,000 exemption deduction could have saved the latter decedent only \$12,000 of estate taxes ($40\% \times \$30,000$). For this reason, the \$60,000 exemption was replaced with an estate tax credit which affords the same estate tax savings to the decedent in a low estate tax bracket as compared to a decedent in a higher estate tax bracket, because credits reduce the estate tax involved dollar for dollar regardless of the estate tax rate involved.

Below is a brief statement of the changes made by the TRA and by the TCA to the estate tax deduction sections. The TRA:

1. Amended section 642(g), which is not an estate tax section, to provide that estates must elect to treat selling expenses (of property which is sold or exchanged by an estate) either as deductions under section 2053 (for estate tax purposes), or as sales price reductions for fiduciary income tax purposes;

2. Expanded the number of charities which will qualify for the estate tax charitable deduction;

3. Provided a new limitation on the maximum estate tax marital deduction in the amount of the greater of: \$250,000; and, 50% of the decedent's adjusted gross estate. In addition, the TRA provided a reduction of the new estate tax marital deduction for certain deductions of the new gift tax marital deduction.

4. Provided a new deduction (from adjusted gross estate in arriving at taxable estate) for transfers to certain natural or legally adopted minor children of the decedent; and,

5. Eliminated the \$60,000 estate tax exemption.

In addition, the TCA:

1. Provides two additional modifications to the new estate tax marital deduction reduction rule in regard to: the gifts which a decedent gave to the decedent's spouse and which were excluded by the \$3,000 annual gift tax exclusion for gifts of present interests; and, the gifts which a decedent gave to the decedent's spouse and which were required to be included in the decedent's gross estate, for estate tax purposes, under section 2035; and,

2. Expands the new minor's estate tax deduction rule to allow more types of transfers to qualify for the deduction.

Spend thirty minutes with us. You may never buy a car again.

Before you buy, you owe it to yourself to talk with Dave Waite Leasing. We've built our reputation on making leasing easy to understand. And easy to afford.

Leasing a car is not reserved for businessmen. Leasing is for anyone who wants to hold their transportation expenses to a minimum.

And for many people, leasing offers advantages not available when buying. There is no down payment necessary when you lease. There are possible savings on insurance costs. The interest rate to lease runs lower than the rate to buy. And Dave Waite will lease you any car or truck sold in America today.

If you're planning to purchase a new car soon, wait until you spend 30 minutes with us.

The more you know, the more you'll agree: Dave Waite Leasing is The Intelligent Alternative to buying your next car.

Visit or call your nearest Dave Waite Leasing location.



Dave Waite Leasing

Indianapolis (3 locations) • Anderson/Muncie
Lafayette • Kokomo • Bloomington

The Dave Waite Leasing Program has been officially endorsed for the membership of the Indiana Dental Association, The Indiana Grain & Feed Association, Inc., the Home Builders Association of Indiana and the Indiana State Bar Association.



ROCKWOOD

INSURANCE COMPANY OF INDIANA

Professional Liability Insurance Specialists

Physicians, Surgeons, Dentists

Hospital Professional Liability

Represented by:

Health Care Provider Insurance Agency, Incorporated

INDIANAPOLIS . . . Hadley-Mahoney Co., 3640 N. Washington Blvd. 46205
(317) 924-5331

MICHIGAN CITY . . Lindenmeyer Insurance Associates, Inc.
801 East Eleventh Street 46360
P.O. Drawer C
(219) 879-7301

SEYMOUR Wienco, Inc., Room 20, Vehslage Building
P.O. Box 518 47274
(812) 522-2931

SOUTH BEND . . . Hepler-Smith Insurance, Inc.
511 West Colfax Avenue
P.O. Box 1875 46634
(219) 232-4889 (Toll Free 1-800-552-2910)

ANCEF[®]
brand of sterile
CEFAZOLIN SODIUM
GETS TO THE SITE



**OF SERIOUS
RESPIRATORY INFECTIONS**

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported:
Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocytopenia and positive direct and indirect Coombs tests have occurred.
Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported.
Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

**ANCEF® IV
IM**
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)
Injection: 250 mg., 500 mg. and 1 gram vials



Dr. Harry W. Salon

"If I were to start today, I wouldn't take anything except medicine. . . ."

Retirement: Perhaps His Greatest Challenge

A little smile flickers often in his eyes and around his mouth as Harry Salon, M.D., reminisces on his 52 years in the medical profession.

A slender, alert man who easily recalls names of doctors and patients he knew more than a half-century ago, Dr. Salon this spring bade affectionate farewells to several patients, some of whom he had served since beginning his practice in a little house still standing at 1414 W. Main St., Fort Wayne.

Story and photo courtesy of THE NEWS-SENTINEL, Fort Wayne. The original article, written by Sharon Little, was published in April 1978. Photo by John Stearns.

The son of Russian Jews who immigrated to the U.S., Dr. Salon estimates he has cared for "thousands" of people since his graduation in 1925 from the University of Michigan Medical School. In ending his career at the age of 77 and thus severing relationships with longtime patients, with whom he often developed close emotional involvement, he says he's "losing an awful lot. The profession has been kind to me."

A man who believes "if you don't have an ego, you have two strikes against you," Dr. Salon says his own ego has been boosted often in his career. "It's been such a rewarding experience—the gratification of seeing a patient get well." And, he quickly adds, "If I were to start today, I wouldn't take anything except medicine."

Dr. Salon, a senior member of the Indiana State Medical Association, says he was "blessed" to have practiced during an "important renaissance" period in medicine. He cites the discovery of insulin, of antibiotics such as streptomycin for tuberculosis ("I've had only one case of TB in the last 20 years"), of sulpha, and of electronic diagnostic equipment.

And, of course, there was penicillin, which he first read about in a medical journal in the early 1940s. When a Fort Wayne woman, Callie Carson, became seriously ill with an infection of the inner lining of the heart and was "in a coma and dying" at St. Joseph's Hospital, Dr. Salon decided to try to obtain penicillin to save her life. He was the first Fort Wayne doctor to treat a patient with penicillin.

Believing "if you yell loud enough you can get what you want," Dr. Salon persuaded the patient's husband, Harold, to have friends and relatives send telegrams to President Franklin Roosevelt, urging release of the new drug. The 400 resulting wires were impressive, Roosevelt relayed his consent by wire to Dr. Salon, and the drug was soon on its way by train to Fort Wayne from a Chicago laboratory.

"Harold Carson and I met the 2:15 train from Chicago . . . the conductor was carrying the penicillin in his pocket and said he had been told to 'deliver this to Dr. Salon and no one else,'" he recalls.

The jubilation of that experience still shines in his face as he remembers the thrill of getting the drug and being able to give it, intravenously, to Mrs. Carson "at 3 a.m." March 8, 1944. "Within 24 hours a miracle happened," he says. "Her temperature came down . . . and in three days she was normal and uttering sounds again." Mrs. Carson, incidentally, is still living.

He had a similar experience using sulfa to treat a local woman whose serious chronic blood disease had no known cure. That woman called Dr. Salon just before he retired, reporting she had never had a recurrence of the illness.

Dr. Salon likes to talk not only of patient-related experiences, but also of his family. The Salons, he says, fled Russia because of an unfavorable political situation; he was born only a few weeks after his mother arrived in New York City by ship. The sixth of the couple's nine children, Dr. Salon was still an infant when the family moved to Fort Wayne, in November 1901, and "stayed here ever since." A nephew, Joel, also is practicing medicine in Fort Wayne.

His older brother, Nathan, who died last year, also was a doctor, and Dr. Salon thinks the two were subtly influenced toward medical careers because their mother's two sisters were dentists in Russia. However, two prominent Fort Wayne doctors in the late 1800s and early 1900s—Isaac Rosenthal and son, Morris—also had an impact on their career choice.

The Drs. Rosenthal cared for the young Salon family, initially "because Isaac Rosenthal spoke German and mother could talk German." His son, Morris, "had a great influence on us," although the families were not social friends. He and Nathan "went to the University of Michigan because Morris Rosenthal went there, and we both did additional medical studies in Vienna," again following Rosenthal's example. "We seemed unconsciously to follow in his footsteps without realizing the fact."

Recollection of how he earned money to pay for his university expenses causes him to chuckle, but Dr. Salon admits he never has talked about it before because he was afraid of the effect the story would have on his patients.

He worked for a Piqua, Ohio, firm which sold Porter's Pain King, billed as a "medicine" good for "humans, horses, dogs, chickens, everything!" he says. The product, he later learned, contained "90 per cent alcohol and 10 per cent cayenne pepper," the latter to "give a feeling of warmth" when people rubbed it on their bodies. The product was popular among farm families of Allen, DeKalb, Noble and Whitley counties, where they bought it for "a dollar a bottle or three for \$2.75." Dr. Salon says Pain King helped him "clear maybe \$600 or \$700 during those 12 weeks of summer."

As he ponders retirement—perhaps his greatest challenge ever—Dr. Salon, a widower, is considering moving to a warmer climate and possibly returning to college to "learn how to write." He knows it will be difficult to put aside the problems and health cares of his patients—he still sees a couple through house calls—because "I loved people and I think they liked me." Patients' "expressions of appreciation and love and admiration . . . satisfied me, I know," he admits.

Dr. Salon will only predict that "whatever I do, I won't be satisfied unless it's something unusual. It's bad when you have only yourself to think about—that makes it very difficult."

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When Impotence is due to androgenic deficiency.

Android[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. / mg. / mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

MeadJohnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4269

This asthmatic isn't worried about his next breath...

he's active
he's effectively
maintained on

QUIBRON[®]

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R3

THE JOURNAL, in cooperation with the Division of Postgraduate and Continuing Medical Education of the Indiana University School of Medicine, offers its readers a Continuing Medical Education program. This is the 9th in a series of CME articles, produced by the faculty of the School of Medicine and is supported by a grant from its Division of Postgraduate and Continuing Medical Education.

As an organization accredited for continuing medical education, the Indiana University School of Medicine certifies that this continuing medical education activity meets the criteria for 1 credit hour in Category I for the Physician Recognition Award of the American Medical Association provided it is used and completed as designed.

To obtain Category I credit, complete the quiz on Page 840.

A Simplified Approach to Dysfunctional Uterine Bleeding

LEO M. BONAVENTURA, M.D.
ROBERT E. CLEARY, M.D.
Indianapolis

OUR current understanding of the normal menstrual cycle is the basis for our approach to the patient with dysfunctional uterine bleeding (DUB).

The secretion of FSH and LH is sustained by the tonic center in the ventromedial arcuate area of the hypothalamus. The characteristic mid-cycle surge of LH is controlled by the cyclic center located in the pre-optic area of the hypothalamus. Dysfunction of this cyclic center

Figure 1 DEFINITION

Dysfunctional Uterine Bleeding is bleeding from noncyclic secretion of gonadotropins and irregular hormone production by the ovary.

From the Department of Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis 46202.

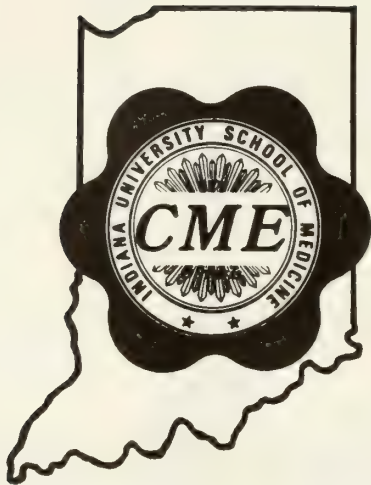


Figure 2
ETIOLOGY OF ABNORMAL
UTERINE BLEEDING

- A. Pathology of the cervix, endometrium, or endosalpinx**
1. Cervical erosion
 2. Endocervical polyp
 3. Cancer of the cervix
 4. Endometrial polyp
 5. Submucous leiomyoma
 6. Chronic endometritis (tuberculosis)
 7. Adenomyosis
 8. Cancer of the endometrium
 9. Cancer of the fallopian tube

can lead to dysfunctional uterine bleeding.

Dysfunctional uterine bleeding is defined as bleeding resulting from noncyclic secretion of gonadotropins and irregular hormone production by the ovary (*Figure 1*). In nearly all instances it is produced by anovulatory cycles.

The term "dysfunctional uterine bleeding" is most often confused or interchanged with the term "abnormal uterine bleeding." The diagnosis of dysfunctional uterine bleed-

ing is made by excluding other causes of abnormal bleeding. Pathology involving the epithelium of the reproductive tract, certain complications of pregnancy, and systemic disorders must be ruled out before the diagnosis of DUB is made. *Figure 2* illustrates several local uterine disorders associated with abnormal uterine bleeding. Trauma, cancer of the cervix, submucous fibroids, cancer of the endometrium, tuberculosis, endometrial polyps, or erosion may also produce abnormal uterine bleeding. Complications of pregnancy (*Figure 3*) can also mimic dysfunctional uterine bleeding. These causes are threatened abortion, ectopic pregnancy, and hydatidiform mole, or a malignant mole. *Figure 4* demonstrates the systemic disorders that can confuse the diagnostic picture. All of these

Figure 3

- B. Complications of pregnancy**
1. Threatened abortion
 2. Ectopic pregnancy
 3. Hydatidiform mole

Figure 4

- C. Systemic disorders**
1. Blood dyscrasias
 2. Anticoagulant therapy
 3. Metabolic abnormality
 4. Endometriosis
 5. Pelvic inflammatory disease

could present initially with the symptom of abnormal uterine bleeding.

Blood dyscrasias, i.e., thrombocytopenic purpura, Factor VII, leukemia, von Willebrand's disease, will rarely produce abnormal bleeding. Anticoagulant therapy can present as bleeding, but a good history will help delineate that specific problem. A metabolic disease that can predictably lead to bleeding is hypothyroidism. Inflammatory disease of the tube and ovary, as well as endometriosis, can produce abnormal uterine bleeding.

Figure 5
DIAGNOSTIC AIDS

1. Pap smear and/or cervical biopsies
2. D & C (fractional)
3. Hysterosalpingogram
4. BBT
5. Immunological test for pregnancy
6. Thyroid function studies (seldom necessary)

As mentioned earlier, the diagnosis of dysfunctional uterine bleeding is by exclusion. *Figure 5* shows diagnostic aids. First, you take a Pap smear and cervical biopsies if a lesion is seen on the cervix. In adolescents, you should avoid instrumentation if at all possible. Dilatation of the endocervix of these adolescents may result in an incompetent cervix during pregnancy. This does not mean that a suction biopsy or vacuum aspiration instrument cannot be used. These instruments are small enough to allow biopsy without dilatation in most instances.

In perimenopausal or postmenopausal patients, or in a patient

suspected of having a malignancy, a curettage is certainly indicated.

If a D & C is performed, this obviously should be fractional (separate curettage of the endocervix and endometrial cavity) to define the specific area of the lesion. A hysterosalpingogram (dye insufflation of the uterine cavity and tubes) may be helpful if secretory endometrium was obtained on the curettage. Occasionally, a small endometrial polyp or submucous myoma, not picked up by the D & C, may be present. The BBT (basal body temperature) record helps to substantiate the diagnosis of anovulatory cycles as the cause of dysfunctional uterine bleeding. The immunological test for pregnancy, if positive, will exclude the diagnosis of dysfunctional uterine bleeding.

Dysfunctional bleeding can then be broken down into the three categories illustrated in *Figure 6*.

Figure 6

- D. Dysfunctional Uterine Bleeding**
1. Postmenarche
 - a. Polycystic ovarian disease
 - b. Stress-induced menstrual abnormalities
 2. Perimenopause
 - a. Declining ovarian function
 3. Postmenopause
 - a. Extraglandular formation of estrone

In the postmenarchal age group, the two most common problems related to dysfunctional uterine bleeding are polycystic ovarian disease and stress induced bleeding. Both are associated with anovulatory cycles or dysfunction of the cyclic center. The perimenopausal group presents with dysfunctional uterine bleeding because of progressive loss of ovarian function. This loss leads to anovulation. In the postmenopausal patient, the dysfunctional bleeding can result from increased peripheral conversion of androstenedione to estrone.

Several factors can govern the choice of therapy in dysfunctional bleeding (*Figure 7*). A primary concern is the amount of blood lost. If the patient has hemorrhaged to the extent that she requires a transfusion, and her bleeding continues to be heavy, a curettage is required. If the intervals between bleeding episodes are far apart, and the cause is anovulatory cycles, it is possible to control this patient's bleeding with the cyclic use of the pill, which will give predictable bleeding episodes of short duration

Figure 7
FACTORS GOVERNING CHOICE OF THERAPY

1. Amount of blood loss
2. Interval between bleeding episodes
3. Presence of anemia
4. Age of the patient

at regular intervals. In the older patient who has no further interest in childbearing, and who has chronic iron deficiency anemia and a history of previous D & C's, hysterectomy may be the definitive therapy. It, of course, would be necessary to do a Pap smear and/or a cervical biopsy and endometrial biopsy to rule out carcinoma of the cervix and of the endometrium before proceeding with the hysterectomy. On the other hand, if the patient is an adolescent and the bleeding mild, you would hope to control the bleeding with a progestin alone, or with the cyclic use of an estrogen-progestin combination. In this latter instance, you would have to rule out threatened abortion and ectopic pregnancy by careful history and pelvic exam.

Therapy in patients with dysfunctional uterine bleeding can be divided into two parts: 1) Measures to arrest hemorrhage, and; 2) Measures to prevent recurrence. *Figure 8* illustrates the measures to arrest hemorrhage. Faced with the

Figure 8
MEASURES TO ARREST HEMORRHAGE

1. D & C if necessary
2. a. High-dose progestin-estrogen combination pill; up to 4 tabs per day for 7 days
 - b. Then a progestin-estrogen combination pill for 3 months cyclically
3. Hysterectomy

adult patient with heavy bleeding and a fall in the hematocrit, a curettage may be not only diagnostic but in many cases therapeutic. If the bleeding occurs in the adolescent patient or teenager, moderate bleeding may be arrested by progestin-estrogen therapy for 7 days. Any high-dose pill (containing 100 micrograms of ethinyl estradiol or mestranol) will suffice. The progestin-estrogen combination is given as 4 pills per day for 7 days. When the pills are stopped at the end of 7 days, the patient will have a heavy flow 2 to 7 days after withdrawal. Following withdrawal flow, a progestin-estrogen combination is given for 3 months. If the patient is concerned about avoiding pregnancy, the therapy can be continued indefinitely. If the patient does not have this concern, the pill may be discontinued in 3 months. If the young patient has had only mild bleeding, the initial step with the intensive use of a progestin-estrogen pill for 7 days may be omitted.

Figure 9
MEASURES TO PREVENT RECURRENCES

- A. Estrogen-progestin combination
- B. Progesterone or progestin alone
- C. Clomiphene 50 to 150 mg. times 5 days

Figure 9 illustrates the measures to help prevent recurrences of DUB. In most patients, the use of an estrogen-progestin combination is most satisfactory. You can also

use one IM injection of 100 mg. of progesterone in a vegetable oil suspension or Provera® 10 mg. tablets for five days to induce secretory change in the endometrium with predictable bleeding 2 to 7 days after the injection or the last tablet. In the adolescent with anovulatory cycles, this would prevent depletion of her iron stores and subsequent development of anemia from recurrent episodes of dysfunctional uterine bleeding. It is best to avoid the use of estrogens in adolescents who have a history of irregular periods because these are the patients who may have protracted periods of amenorrhea following the use of the cyclic estrogen-progestin medications (the pill). In the patient who wishes to conceive, and who has long intervals between episodes of anovulatory bleeding, you may induce ovulation with the use of clomiphene citrate.

The natural history of dysfunctional uterine bleeding resembles that of the patient with oligomenorrhea. The reason for the similarity in the natural history is that both are often associated with anovulation. You can see from Figure 10 that 50% of patients with dysfunctional uterine bleeding will have a

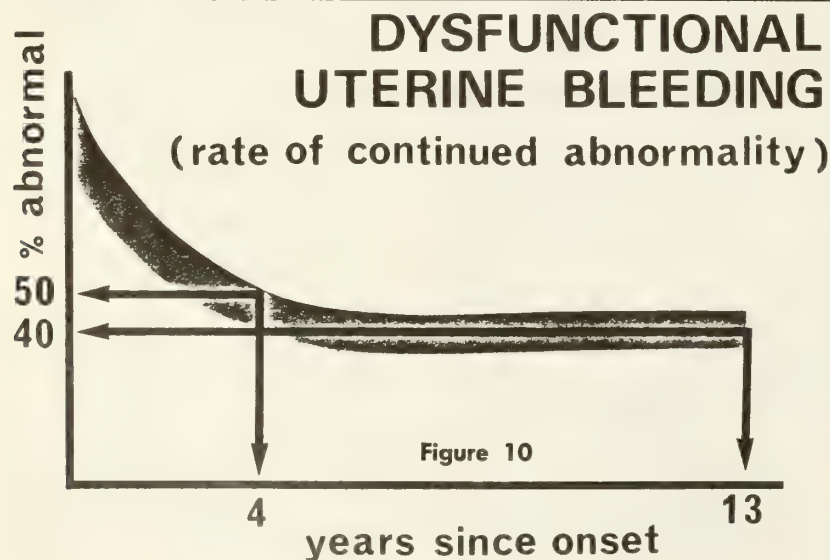
resolution of their symptoms in the first four years after menarche. Almost all cases that persist beyond four years, as shown in the graph, will continue indefinitely.

Outmoded and discredited methods unfortunately continue to be employed today. Toluidine blue, ergot, and oxytocin were early attempts to control uterine bleeding. Irradiation was another method employed in the past. The inability to predict the development of permanent amenorrhea and the increased risk of leukemia and cancer of the irradiated tissues have led to its disuse. Testosterone has been successful in controlling bleeding, but its virilizing property was an unacceptable side effect. Following the development of the synthetic progestins with their potent progestational action and minimal androgen effect, testosterone and its analogues were discarded. Recently the use of antifibrinolytic agents such as epsilon aminocaproic acid (EACA) and tranexamic acid (AMCA) have been advocated for treatment of uterine bleeding. Since these drugs have not been approved by the FDA for dysfunctional uterine bleeding, their use cannot be recommended.

In summary, the use of a curettage should not be our first line of treatment. This does not eliminate the use of a biopsy instrument to help us in our diagnosis. The most important stage in the treatment of DUB is to rule out malignancy and pregnancy. After we have ruled out the above, the appropriate steroids for the management of the DUB can be instituted. This management is based on the understanding of the endometrium's response to these hormones. In the end, it is most important that we make the treatment regimen clear and simple enough for the patient to understand; without this key factor all our treatment may be lost.

REFERENCES

1. Aksel, S, Jones, GS: Etiology and treatment of dysfunctional uterine bleeding. *Obstet. Gynecol.* 44:1, 1971.
2. Barry, A: Dysfunctional uterine bleeding. *J. Am. Med. Assoc.* 66: 287, 1973.
3. Altchek, A: Dysfunctional menstrual disorders in adolescence. *Clin. Obstet. Gynecol.* 14:975, 1971.
4. Fraser, IS, Baird, DT: Blood production and ovarian secretion, rates of estradiol-17 β and estrone in women with dysfunctional uterine bleeding. *J. Clin. Endocrinol. Metab.* 39: 564, 1974.
5. Fraser, IS, Michie, EA, Wide, L, et al.: Pituitary gonadotropins and ovarian function in adolescent dysfunctional uterine bleeding. *J. Clin. Endocrinol. Metab.* 37:407, 1973.
6. Novak, ER, Jones, GS, and Jones, Jr, HW: Novak's Textbook of Gynecology, 9th Edition. Baltimore, The Williams and Wilkins Company, pp 688-707, 1975.
7. Scommegna, A, Dmowski, W: Dysfunctional uterine bleeding. *Clin. Obstet. Gynecol.* 16:221-254, 1973.
8. Speroff, L, Glass, R, and Kase, N: Clinical Gynecologic Endocrinology and Infertility. Baltimore, The Williams and Wilkins Company, pp 85-99, 1973.
9. Wentz, AC, Jones, GS, and Karan, S: Pulsatile gonadotropin output in menstrual dysfunction. *Obstet. Gynecol.* 47:300, 1976.
10. Winter, JS, Faimon, C, Reyes, FI: *Clin Obstet. Gynecol.* 21:67, 1978.



Coronary Artery Endarterectomy: Its Role in Myocardial Revascularization

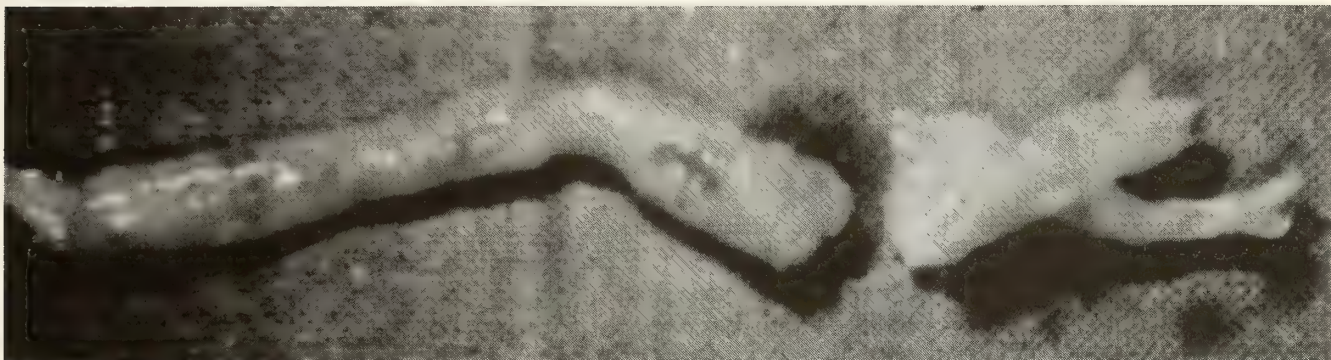


FIGURE 1

Specimen is the endarterectomy core, which demonstrates the bifurcation of the right coronary.

HARRY SIDERYS, M.D.
Indianapolis

PATIENTS AND METHODS

Early in 1972, in the course of bypassing obstructed coronary arteries with saphenous veins, a severely diseased right coronary was opened. The atheroma was ulcerated and much thicker than you could appreciate from the arteriograms. The artery was too diseased to allow successful attachment of a vein graft, so a manual coronary endarterectomy was performed and vein bypass was brought to the endarterectomized coronary artery. Since then the same severely diseased coronary arteries were encountered in an additional 42 patients with the same outcome; i.e., manual coronary endarterectomy was performed with a bypass vein graft after an artery was opened and found too diseased to accept to primary vein graft (*Figures 1 & 2*).

These patients had severe diffuse disease. Twenty-six required triple or quadruple vein bypass grafts, while 17 required single or double grafts.

The right coronary artery is the vessel that lends itself best to endarterectomy because of its large size. In this series endarterectomy and bypass graft was accomplished to the right in 40 patients, to the L.A.D. in two, and to the circumflex in one.

RESULTS

After thromboendarterectomy the flows in the vein graft to the right coronary arteries averaged 56cc per minute, approximately the same flow measured in vein grafts to the right coronary arteries not requiring endarterectomy.

Post operative studies included left heart cardiac catheterization, which was done in 12 patients. In eight the endarterectomized artery and the vein graft to it were patent—a patency rate of 75%. Although most vein grafts in this setting remain patent, the patency in vein grafts to arteries not subjected to endarterectomy has been higher—85%.

Four patients suffered intraoperative infarcts. This rate of 7% is higher than the rate of 4% among those who had bypass surgery without endarterectomy. Post-operative cardiac catheterization was done on the three patients who had operative infarction. In each of these, the vein graft and artery were patent.

MYOCARDIAL revascularization surgery has been extensively practiced and widely accepted over the past eight years. The reversed saphenous vein graft and the mammary artery have provided us with the grafts that have stood the test of time.^{1,2,3}

On occasion, during the course of surgery, a coronary artery is exposed that is so obviously diseased that if it were opened for grafting an endarterectomy would be necessary. Many surgeons avoid coronary endarterectomy under any circumstances because of the reported higher incidence of complications. However, if badly diseased arteries are never opened, the heart will not be completely revascularized.

This dilemma has led to this review of my personal experience with coronary endarterectomy.

From the Department of Medical Research, Methodist Hospital of Indiana, Inc., Indianapolis 46202.

Publication assisted in part by the Showalter Fund.

There were no operative deaths among these 43 patients who had coronary bypass surgery and endarterectomy.

DISCUSSION

Coronary endarterectomy is an operation that surgeons would rath-

er not do. Generally, endarterectomy is done on arteries that are so diffusely diseased that a vein graft would not be performed. The patency rate of endarterectomized vessels and their vein grafts is less than ordinary bypass grafts, but more than half of these grafts and

arteries remain patent.^{4,5,6} The patency rate in this series was 75%. The incidence of operative infarct is higher in patients who have had endarterectomy^{4,5,6} and was 7% in our patients. The three patients with operative infarct had post-operative catheterization and in each patient the vein graft and endarterectomized artery was found to be patent.

The complexity of the operation probably accounts in part for the increased operative infarction. Two-thirds of the right coronaries treated by endarterectomy were totally occluded and three-fourths of the patients with operative infarction had narrowed rather than occluded arteries. This finding suggests that endarterectomy is even safer if limited to a completely obstructed artery.

Coronary endarterectomy increases the complexity of the bypass surgery but there were no operative deaths in this series.

In patients with severe diffuse disease of the distal coronary arteries (particularly the right coronary) coronary endarterectomy will occasionally allow revascularization of an area of myocardium that would not be treated.

REFERENCES

1. Siderys, H, Pittman, J, Herod, G: Coronary artery surgery in patients with impaired left ventricular function. *Chest*, 61:482, 1972.
2. Siderys, H, Pittman, J, Herod, G, Halbrook, H: The influence of coronary artery surgery on survival. *J. Ind. St. Med. Assn.*, 69:2, 85-86, Feb. 1977.
3. Siderys, H: Reoperation for failure of coronary artery bypass surgery (The role of mammary artery grafts). *J. Ind. St. Med. Assn.*, 70:2, 70-71, Feb. 1977.
4. Cheanvechai, C, Groves, L, Reyes, E, Shirey, E, Jones, F: Manual coronary endarterectomy. *J. Thorac. Cardiovasc. Surg.*, 70:524, 1975.
5. Theman, T, Stoik, G, De La Rocha, A, Gunstenson, J, Trimble, A, Aldridge H: Aortocoronary bypass made possible by coronary endarterectomy. *Can. J. Surg.*, 19:429, 1976.
6. Yacoub, M, Fawzy, E, Anyanwu, H, Towers, M: Combined gas endarterectomy and coronary artery bypass graft. *Circulation Supplements*, 52:1-182, 1975.

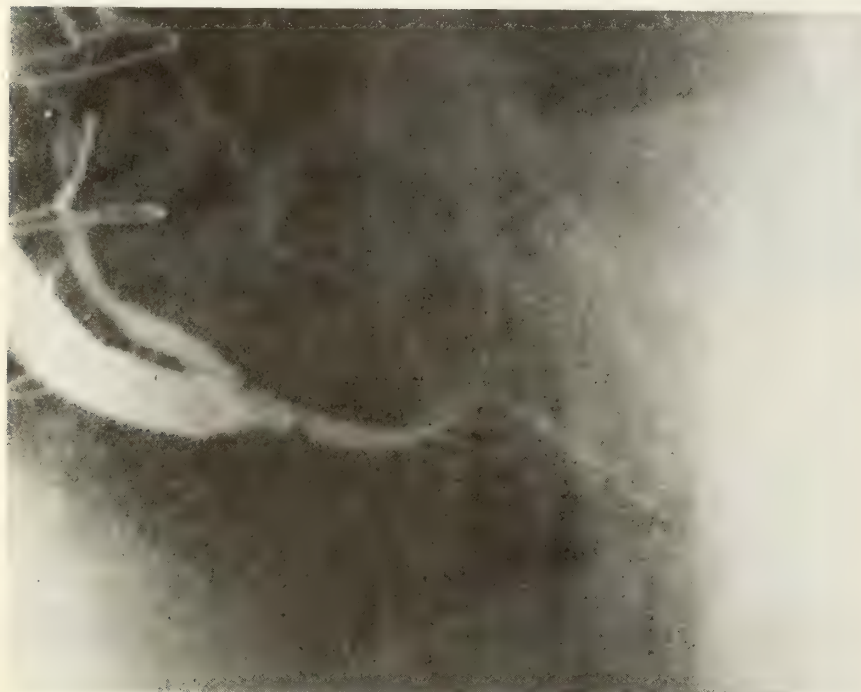
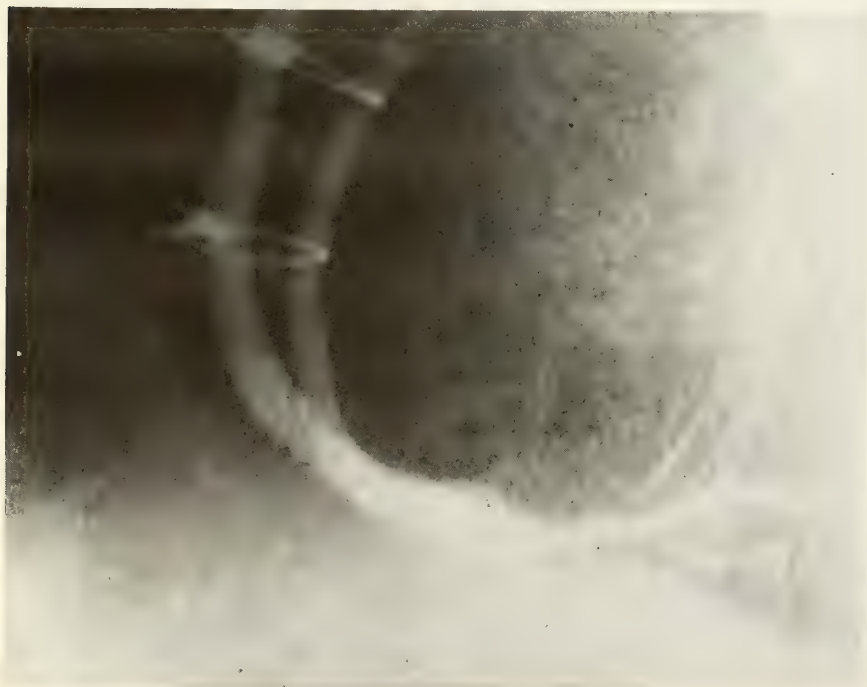


FIGURE 2—A & B

Post op arteriograms in two patients who had endarterectomy of completely obstructed right coronary arteries. In each the vein graft and the branches of the right coronary artery are patent.



Thyroid Function Tests for the Practicing Physician

A LARGE number of thyroid tests have become available over the last 10 to 15 years and for various reasons continue to be somewhat confusing. We shall concentrate on biochemical thyroid testing, as nuclear medicine techniques are beyond the scope of this paper.

MEASURES OF SERUM THYROXINE

Total serum thyroxine (T_4) may be measured by either competitive protein binding assays or by radioimmunoassay. Both assays are virtually analogous; neither is more specific for clinical purposes than the other. Assays of total thyroxine measure the total level of thyroxine plus a variable fraction of the triiodothyronine (T_3) present. However, since triiodothyronine (T_3) comprises only a small fraction of the circulating thyroid hormone (normally about 1%), this interference is not usually clinically important.

There is no contribution to the assay from exogenous iodinated organic compounds, iodinated proteins, or from iodide itself. Thyroxine is elevated in exogenous or endogenous hyperthyroidism and is depressed when the thyroid fails to supply a sufficient amount of hormone for bodily needs or when pa-

tients are replaced with T_3 only. Total T_4 is also depressed in situations where binding proteins are diminished, such as serious malnutrition, nephrosis, severe liver disease and with the administration of androgens. Thyroxine binding globulin (TBG) is the primary binding protein. It is synthesized by the liver and carries more than 80% of circulating thyroxine. It is the protein whose change is reflected in these conditions.

The effect of variations in plasma binding proteins is not noticed at tissue levels because free hormone concentrations stay remarkably constant once a new steady state of binding protein is achieved. The Free Thyroxine Index, which will be discussed subsequently, is a clinical measurement that corrects for variations in binding proteins.

Dilantin, salicylates, heparin and several other medicines displace thyroid hormone from thyroid binding proteins. In general, if levels of these drugs are relatively constant, no change in physiologic effect is to be expected. However, in patients taking these medicines, total thyroxine could be a rather poor measurement of metabolic status. Estrogens elevate TBG and are responsible for the fairly high T_4 levels seen in pregnant women and women on high-dose birth control pills.

CORBIN P. ROUDEBUSH, M.D.
Indianapolis
GEORGE T. ASTERIS
East Chicago

Another possible problem in interpretation of T_4 values is the rare patient with T_3 secretion in excess of T_4 secretion, " T_3 thyrotoxicosis." In this case, T_4 does not adequately measure metabolic status.

T_3 RESIN UPTAKE (RT_3U) TEST

Unfortunately, this test is sometimes referred to as the T_3 test, a term that is inappropriate since it does not measure serum T_3 . This fact may be quite confusing. The test measures the number of unoccupied T_4 binding sites on TBG. The test result is inversely proportional to this number; thus it is low in patients with an elevated concentration of binding protein, such as in pregnancy. It is increased in patients with low binding protein concentration. Variations in the minor thyroxine binding proteins do not have any major effect on the test. Since RT_3U is dependent upon both the amount of hormone and the number of binding sites, the result is not of itself very useful. However, as we will see below, when combined with the total T_4 in the Free Thyroxine Index (FTI) it becomes valuable in measurement of thyroid function. Although the test is independent of excess free iodide, several drugs that compete for the T_4 for TBG binding, such

From the Departments of Medicine of Methodist and St. Vincent Hospitals, Indianapolis, and St. Catherine's Hospital, East Chicago, Ind.

Reprints are available from Dr. Roubush, Suite 203, 2020 W. 86th St., Indianapolis 46260.

as Oragrafin®, salicylates and heparin may affect it.

FREE THYROXINE INDEX

This test is also unfortunately called by several different names, such as T_7 . It is probably simplest, however, to use the abbreviation FTI or FT_4I . Normally 99.9% of plasma T_4 is bound to thyroxine binding proteins, and this complex is in equilibrium with the .03% of free T_4 in solution. The free T_4 , however, is the physiologically active substance and hence some measurement of it would be an ideal estimate of thyroid function. Since you can measure total serum T_4 and also (the inverse of) the unoccupied binding sites on TBG, a combination of these two factors should theoretically be directly proportional to the free thyroxine. In practice, you multiply a patient's total thyroxine and RT_3U to obtain the free thyroxine index. Some laboratories correct this to a range approximating that of the normal range for T_4 by dividing the patients RT_3U by a control RT_3U . The test has been, in fact, compared to free T_4 determinations done by dialysis and varies linearly over a very wide range of clinical situations. The test almost entirely separates hyperthyroid subjects from normals.

There is slight overlap with some hypothyroid individuals. In patients with abnormal levels of T_4 binding proteins, who are euthyroid, the FTI values fall within the normal range. Thus, the test corrects for changes in T_4 content attributed to variation in binding proteins and gives the clinician a number closely related to the active fraction of the hormone. The assay is not absolutely accurate at extremely high and low values of T_4 , but for clinical purposes this is not terribly important. Several kit methods are available, which perform a similar procedure in one step. These may be

called effective thyroxine ratio (ETR) or normalized thyroxine ratio (NTR).

In general, FTI measurements have stood up somewhat better to the test of time and one recent publication¹ states that ETR may not be as good as T_4 as a screening test for abnormal metabolic states. FTI or ETR measured before any therapeutic intervention may have prognostic significance in ^{131}I therapy of Graves' disease.² Patients with modest elevations of FTI have a higher incidence of early hypothyroidism after ^{131}I than do those with extremely high values. It would be redundant to measure both a T_4 and a RT_3U , and an ETR in any given patient. T_4 , FTI and RT_3U all decrease somewhat between the age of one year and adulthood (age 15); thereafter, they are fairly stable.

TRIIODOTHYRONINE ASSAY

Serum T_3 levels are conveniently measured by radioimmunoassay. T_3 RIA is the most acceptable abbreviation. This test in no way measures binding proteins, but directly measures total circulating serum triiodothyronine (T_3).

In general, T_3 RIA is quite an accurate index of the presence of thyrotoxicosis, but tends to be normal in hypothyroidism. T_3 levels decrease slightly from late infancy until adult life. No seasonal variations have been observed. T_3 levels in older men tend to decrease somewhat, but older women show a less pronounced change.

T_3 RIA may be useful in the occasional patient with a normal T_4 who has T_3 thyrotoxicosis. This syndrome, originally described with thyroid nodules, has now been seen with virtually any of the classic causes of thyrotoxicosis. T_3 RIA may also be elevated in patients taking liotrix (Thyrolar®, Euthroid®) or desiccated thyroid (or Prolloid®); all of which have a high-

er ratio of $T_3:T_4$ than is secreted by the human thyroid.

In general, problems are minimized and the expensive assay is not necessary with the use of synthetic 1- T_4 (Synthroid® or Let-ter®) for replacement purposes. T_3 RIA may be low in patients with serious systemic metabolic illness, newborn infants or in starvation. Apparently, peripheral metabolism of thyroxine is shifted from its normal breakdown to T_3 to a much increased rate of conversion to reverse T_3 (rT_3). rT_3 is a metabolically inert metabolite of thyroxine. While frequently it is argued that such patients may be slightly hypothyroid, no serious clinical consequences of this state have been demonstrated to date.

THYROTROPIN (TSH) MEASUREMENTS

The level of circulating TSH in serum is determined by radioimmunoassay. Most assay methods are quite reliable for elevated levels of TSH, but it is difficult to obtain antibodies with sufficient sensitivity to measure low levels of TSH accurately. Thus, the assay is useful in the diagnosis of hypothyroidism, but is of little use in the diagnosis of hyperthyroidism.

The alpha sub-unit of TSH is identical or quite similar to that of LH (luteinizing hormone), FSH (follicle stimulating hormone) and HCG (human chorionic gonadotropin). High levels of these hormones occasionally cause problems, either in pregnancy or in the post menopausal state and may falsely elevate TSH values. However, most assays currently in use preabsorb TSH antisera with HCG, diminishing the problem. Some institutions are now using radioassays specifically for the beta sub-unit of TSH, which shows no significant cross reactivity with βLH , βFSH or βHCG .

TSH is elevated in hypothyroid

states except when they are secondary to pituitary insufficiency. It also is elevated in compensated, eumetabolic goiter, usually due to Hashimoto's disease. Before the hypothyroid state ensues, TSH levels may not be absolutely absent in patients with apparent pituitary hypothyroidism, but these subjects are usually separable by TRH testing.

THYROTROPIN-RELEASING HORMONE (TRH) TEST³

TRH testing evaluates hypothalamic-pituitary function when the possibility of secondary abnormalities of thyroid function are present. It is also useful in making the diagnosis of hyperthyroidism when borderline FTI and T₃ values are observed. 500 (or 400) micrograms of TRH (7 mcg. per kilogram in children) is given intravenously over 30 seconds. TRH (Thy-pinone®) has been recently released by the FDA and is currently available through most hospital pharmacies. Samples for TSH measurement drawn at 0, 30 and 60 minutes are adequate for clinical evaluations. In normals you see an increment of serum TSH to above the upper limits of normal. In elderly adults, particularly males, a normal response is sometimes not clearly outside the normal limits.

In hyperthyroidism a flat TSH response is seen. In primary hypothyroidism levels about 2 to 3 times the upper limit of normal are seen. However, since basal TSH is elevated in this condition, formal TRH testing is rarely indicated. In secondary hypothyroidism, the pattern may be either delayed or flat, depending upon whether the lesion is at the level of the hypothalamus or pituitary.

The only contraindications to date for this test are allergy, severe hypertension and cerebral vascular disease. The test has largely supplanted the older Werner T₃-suppression test, considered more dangerous.

RADIOACTIVE IODIDE UPTAKE BY THE THYROID

This test, although technically a nuclear medicine procedure, will be discussed briefly. The radioactive iodide uptake (RAIU) is a test of limited usefulness in making a diagnosis of hyperthyroidism or hypothyroidism and is not indicated in following patients with these disorders. Its use is largely limited to dosimetry before treatment with radioiodide, and in the differential diagnosis of hyperthyroidism (see "RAIU" below).

The test is not to be confused with thyroid scanning, which is of great use in defining anatomic abnormalities in the thyroid. The range of normal values for RAIU has changed significantly over the past 10 to 20 years because of increased iodide intake by the population (in such products as enriched breads, iodized salt and many of the commercially available fortified cereals and vitamins). Current normal ranges run about 10% to 25%, but must be individualized for each laboratory.

RAIU is useful in the diagnosis of subacute thyroiditis where uptakes greater than 5% make the diagnosis quite unlikely. Very low uptakes may also be seen in massive iodide ingestion, hyperthyroiditis,⁴ thyrotoxicosis factitia and with struma ovarii.

THYROID ANTIBODIES⁵

Two antithyroid antibodies, thyroglobulin (TGHA) and microsomal (MCHA), are measured in clinical practice. Both are measured with serial dilution hemagglutination techniques, available in kits, although multiple methods have been developed for their measurement.

The utility of these antibodies is in differential diagnosis of immune thyroid disease, for example, in a patient with apparent euthyroid exophthalmos or diffuse goiter (euthyroid Hashimoto's disease). They

are also useful in confirming the diagnosis of Graves' disease or Hashimoto's thyroiditis in symptomatic patients. Antithyroglobulin antibodies have been found to be present in approximately 60% of patients with Hashimoto's disease and 30% of patients with Graves' disease. The newer microsomal antibodies are present in approximately 95% of patients with Hashimoto's disease and 85% with Graves' disease.

Occasional false positives are encountered in patients with other diseases associated with immunologic abnormalities, such as pernicious anemia, rheumatoid arthritis, multiple myeloma, Turner's syndrome, vitiligo, Hodgkin's disease and diabetes mellitus. However, since immune thyroid disease is often coexistent with these entities, it is difficult to tell if these are really false positives. Tests of antibody functions are highly useful in diagnosing the presence of thyroid disease and should be used more by the practicing physician, particularly as they become more widely available.

SHORT BIBLIOGRAPHY

1. Kuman, MS, Safa, AM, Deodhar, SD and Schumacher, PP: *Cleveland Clinic Quarterly*. 44:1-7, 1977.
2. Roudebush, CP, Hoyer, KE and DeGroot, LJ: Compensated low-dose ¹³¹I therapy of Graves' Disease. *Annals of Internal Medicine*, 87:441-443, 1977.
3. Pittman, JA: Thyrotropin-releasing hormone. *Advances in Internal Medicine*, 19:303-325, 1974.
4. Gluck, FB, Nusynowitz, ML and Plymate, S: Chronic lymphocytic thyroiditis, thyrotoxicosis, and low radioactive iodine uptake. *New England Journal of Medicine*, 293:624-628, 1975.
5. Amino, N, Hagen, R, Yamada, N and Refetoff, S: Measurement of circulating thyroid microsomal antibodies by the tanned red cell maemagglutination technique: Its usefulness in the diagnosis of autoimmune thyroid diseases. *Clinical Endocrinology*, 5:115-125, 1976.

CME QUIZ

Dysfunctional Uterine Bleeding . . .

CONTINUED FROM PAGES 831-834

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.**

ANSWER THE FOLLOWING:

- Ovulation is controlled by which center in the hypothalamus?
 - Tonic center.
 - Cyclic center.
 - Anterior pituitary.
 - Posterior pituitary.
- Dysfunctional uterine bleeding is:
 - Any bleeding that can be attributed to pathology of the cervix, endometrium, or endosalpinx.
 - Bleeding from cyclic secretion of gonadotropins and regular hormone production by the ovary.
 - Bleeding from noncyclic secretion of gonadotropins and irregular hormone production by the ovary.
 - Any bleeding from the uterus in the reproductive age group.
- Dysfunctional bleeding in the postmenarchal age group is due to:
 - Anovulatory cycles.
 - Endometriosis.
 - Pelvic inflammatory disease.
 - Ectopic pregnancy.
- The cause for dysfunctional bleeding in the perimenopausal group is:
 - Exogenous estrogens.
 - Polyps.
 - Declining ovarian function leading to anovulatory cycles.
 - Elevated gonadotropins and elevated estrogens.
- Which factor is most important in governing the choice of treatment in dysfunctional uterine bleeding?
 - Age of the patient.
 - Amount of blood loss.
 - Interval between bleeding episodes.
 - Weight of the patient.
- In the adolescent or teenager with heavy dysfunctional uterine bleeding, the choice of treatment is:
 - Hysterectomy.
 - D & C.
 - Bedrest.
 - Hormonal therapy.
- In the older patient who does not desire future fertility and has had a previous D & C for DUB, the treatment of choice is:
 - Hormonal therapy.
 - Another D & C.
 - X-ray therapy.
 - Sample endometrium; if normal, proceed with hysterectomy.

The following are answers to the CME quiz that appeared in the June 1978 issue of *The Journal*. The article upon which the questions were based was "HDL Cholesterol and Atherosclerosis," by Richard C. Powell, M.D.

- b, c
- b
- b
- b

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer sheet for Quiz: (Uterine Bleeding)

- | | |
|---------------|---------------|
| 1. a, b, c, d | 5. a, b, c, d |
| 2. a, b, c, d | 6. a, b, c, d |
| 3. a, b, c, d | 7. a, b, c, d |
| 4. a, b, c, d | |

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of *THE JOURNAL* for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

The Division of Postgraduate and Continuing Medical Education must receive your completed, signed application before November 15, 1978, to be eligible for credit for this month's quiz. Answers to the quiz will appear in a later issue.

The Royal College of Surgeons of England

MALCOLM B. HERRING, M.D.
Indianapolis

AN EXPLANATION of the burning of John Hunter's manuscripts is proposed by Doctors Livesley and Pentelow.* It has been assumed that Hunter's brother-in-law, Sir Everard Home, had destroyed the papers to conceal the fact that he had used Hunter's work as his own. The idea that Home was the subject of the famous inoculation experiment in which syphilis was transmitted by inoculation is an interesting consideration.

* * *

Factors predisposing to life threatening surgical infections are carefully analyzed by Professor Kune of Melbourne. A 13.3% incidence in 917 patients was observed retrospectively and a prospective study of 50 patients confirmed that factors such as malnutrition, malignancy, anemia and hypoalbuminemia delayed hypersensitivity skin tests, and others were clearly related to life threatening infections.

* * *

BCG therapy has been found to have beneficial effects in patients with melanoma. This is reviewed by Ali A. El-Daneiri.

* * *

The Reilly phenomenon is reviewed by Drs. Hopkin and Laplane emphasizing the careful experiments and observations of James Reilly. The effect of stimulation of sensory sympathetic fibers on inflammatory processes and immunity, pathophysiology of infectious disease and numerous pathological processes is considered. Irritation of an artery results in significant hyperplasia of the endothelium, which can be blocked by sympathetic innervation. Numerous other effects are reviewed that would be of interest to all physicians.

* * *

A bust of John Hunter, considered the founder of scientific surgery, was dedicated on the 250th anniversary of his birth to mark the celebration of the Silver Jubilee of Her Majesty Queen Elizabeth II.

* * *

Mr. David Rosin explored the efficacy of using isolated segments of colon for dialysis and concluded after a very careful study in sheep and humans that it may have a place as an adjunctive treatment of renal failure.

* * *

A careful follow-up of mass suture closure with Dexon resulting in a low incidence of dehiscence and hernia is described by Dr. Bentley and others.

* * *

The Hazards of the Breech by A. G. W. Whitfield describe the birth of Kaiser William II to Queen Victoria's daughter and the life-long effect of a withered arm. The opinions of Sir Benjamin Brody, Sir James Padgett and Sir James Clark reflect the surgical attitudes of the 19th Century.

* * *

The unwrapping of a mummy named Horseisi at the Royal College of Surgeons is described by Dr. Clifford Brewer. T. W. Pettigrew Esq. F. R. S. unwrapped several mummies that had been sold at auction at Sotheby's in 1833 for about \$75. Mr. Pettigrew then unwrapped the Royal College mummy with numerous interesting observations.

* * *

The celebration of Lord Nuffield's centenary revealed the extent of the philanthropy of the English equivalent of Henry Ford. He was thought to have donated £32 million in his life time.

* * *

*The information in this article is based on the March 1978 issue of the Annals of the Royal College of Surgeons of England.

Your Patient Saves Dollars with Generics by PUREPAC

Here's Proof!

These products and prices were taken directly
from newspaper advertising by various retail pharmacies.

QUANTITY	BRAND NAME	PRICE	PUREPAC GENERIC	PRICE	SAVINGS
30	Polycillin (250 mg.)	\$8.70	Ampicillin (250 mg.)	\$2.40	\$6.30
100	Equanil (400 mg.) [Ⓢ]	8.09	Meprobamate (100 mg.) [Ⓢ]	1.83	6.26
100	Darvon Comp. 65 [Ⓢ]	7.83	Propoxyphene HCl Comp. 65 [Ⓢ]	4.63	3.20
100	Pavabid (150 mg.)	11.73	Papaverine HCl T.R. (100 mg.)	4.33	7.40
100	Thorazine (50 mg.)	6.03	Chlorpromazine HCl (50 mg.)	3.23	2.80
100	Librium (10 mg.) [Ⓢ]	7.11	Chlordiazepoxide HCl (10 mg.) [Ⓢ]	4.89	2.22

The savings add up! So, when you prescribe generics, specify Purepac,
the largest generic manufacturer in America.

Brand names are registered trademarks of
Bristol Labs., Wyeth Labs., Eli Lilly & Co.,
Marion Labs., Smith Kline & French Labs.,
Roche Labs. respectively.



PUREPAC

Elizabeth, NJ 07207

AMERICA'S LEADING NATIONAL BRAND OF GENERICS

From The Journal 50 Years Ago

Tomato Juice . . .

A few months ago a prominent dietician announced that raw sauerkraut and especially sauerkraut juice is a wonderful tonic and alternative. Almost immediately the menu cards of the dining cars on our leading railroads and our "swell" hotels in all large cities added sauerkraut juice to the bill-of-fare. Now comes another announcement to the effect that the juice from raw tomatoes is a good team-mate of sauerkraut juice. So falling in line are the dining cars and our leading hotels with tomato juice on the bill-of-fare. Thus on one menu card we noted that sauerkraut juice is listed at forty cents, and below it is tomato juice listed at the same price. Sauerkraut juice may have had its origin in Germany, where for a long time it has been very popular, but tomato juice drinking is distinctly an American innovation, though it is said that already it has spread to France and Italy. If you will pin your faith to tomatoes, be sure to have ripe tomatoes, without scalding, without other seasoning than salt, and don't omit to consume the juice. If whole tomatoes are used they should be skinned without the use of hot water, and consumed raw.

'Pauperism' . . .

We wish it distinctly understood that we are not opposed to child welfare work when it is conducted along proper lines. What we object to is the free clinics for all who come, with the bestowal of valuable medical advice, even to the point of prescribing for the patient, as a pure gratuity and with the unavoidable result of stimulating pauperism and dependency to say nothing of loss of self-respect on the part of a class of people who should have far different encouragement. We do not doubt that boards of health, child welfare associations, parent-teacher associations and other uplift organizations sincerely believe that they are performing a valuable service to society when they aid in the preservation or promotion of health through free clinics, but sometimes a lot of harm is done by misguided enthusiasts who bestow misplaced charity. We ought to bend every effort to make people self-sustaining and independent and desirable citizens of our country, and we can't do this if we are going to put into practice any paternalistic or socialistic ideas.

JISMA, September 1928

Navy Medicine. The time is right.

Now's the time to look into Navy Medicine.

It was never more attractive than it is today. As a physician in the Navy, you'll practice the finest in patient care and followup, in facilities that rank with the top anywhere. With the support of a skilled paramedical and administrative staff. As a General Medical Officer or a Navy Flight Surgeon, or in your own specialty—or in one of ours like aerospace medicine or undersea medicine.

You'll start right in with a full-scale practice and, depending on individual circumstances, earn \$30,000 or more a year to start. You can count on time to relax, with 30 days' paid vacation earned each year. Whether you choose a medical facility in the United States or overseas or sail with the Fleet, you'll combine professionalism, public service and adventure in a way of life that's uniquely Navy.

The time is right. To learn more, to find out whether we have openings in your specialty, and to find out if you qualify, contact:

LT. BOB JONES, R.N., B.S.N.
575 N. Pennsylvania St. R. 643
Indianapolis, IN 46204
(317) 269-6197 (COLLECT)

It makes sense now.



AUXILIARY REPORT

Ruth (Mrs. G. Beach) Gattman
President, ISMA Auxiliary

This month's Auxiliary Report was prepared by Dorothy (Mrs. Everett) Bickers of Floyds Knobs, chairman of Auxiliary Activities, 1978 ISMA Convention.

We hope you are planning a "Getaway to the South" in October when the Indiana State Medical Association holds its annual convention at the Marriott Inn in Clarksville. You'll find the Marriott to be a fabulous resort inn—swimming pools, tennis courts (indoor and out), lake health club and golf courses nearby. So bring along your swimsuit, tennis racquet and/or golf clubs as well as your prettiest outfit and dancing shoes. You will be thrilled not only by the beauty of southern Indiana in the fall, but also some points of interest in our neighboring state of Kentucky.

We'll begin with a tour Sunday afternoon (advanced reservations a must), taking you to Louisville where stops will be made at world-famous Churchill Downs and Locust Grove, last home of George Rogers Clark. You will be treated with a Kentucky Mint Julep (something not easy to find in October) and hors d'oeuvres before you are returned to the Marriott. If your spouse is going to be involved with reference committee meetings Sunday evening, I suggest you make plans to see Cyd Charisse in "Kindling," which will be playing at the Derby Dinner Playhouse.

Next, start your Monday morning off right with exercise time at the Kentuckiana Sports Center. The Health Club Director will be there to give an exercise demonstration and a tour of the facilities. Whether you choose to be a spectator or to participate, there will be adequate time to return to the Inn and get ready for an exciting all-day tour. A scenic one-hour bus ride will take you to the Wakefield Searce

Galleries at Shelbyville, Ky. The silver and antique collections are fantastic. Lunch will be served at Claudia Sanders, where the Colonel once packaged those 11 secret herbs and spices. After lunch, we'll motor back through the saddlebred capital of the world and make a shopping stop at Bakery Square. Bakery Square, with 24 unusual shops, is an old kitchen factory in historic Butchertown. Hadley pottery also is in Butchertown. There will be time to relax before you join your spouse for dinner and a moonlight cruise on the "Belle of Louisville."

Tuesday is "Auxiliary Day." President Ruth Gattman will preside at an open Board Meeting. At lunch you will be entertained by charming models from Actor's Theatre of Louisville, as they display costumes from a cavalcade of productions with a fascinating narration which provides a "behind the scenes look" at theatrical design, research sources and costume secrets. After lunch, we are invited to stroll across the parking lot to Frame House Gallery where someone will be on hand to tell us the why and how to decorate with printings and about good framing.

This brings us to Tuesday evening and the highlight of the convention, the President's Reception and Dinner.

The convention will end Wednesday, but Auxilians from Clark and Floyd County will still be available to answer questions and give directions if you need help with where to go or what to do.

Looking forward to seeing you in October.



Forget Everything

you ever knew
about borrowing

Money

Introducing a new loan:

THE PROFESSIONAL

so unique that we have over \$4,000,000.00 in personal loans made to Physicians and Dentists.

Unique Features...

- **PAY ANY AMOUNT ANY DAY OF THE MONTH.**

In good times, pay more. During slow periods, pay the minimum.

- **WE MAKE HOUSE CALLS.**

A collect call is all that's necessary to begin processing your loan. We will come to your home, office or hospital to close your loan at your convenience.

This confidential loan is made for any good purpose . . . long term or short . . . \$10,000 to \$50,000. An interest-bearing loan, it can be repaid in varying amounts and on any day. You pay only for the time you use the money. Call today.

PROFESSIONAL LOAN DIVISION

Ask for Colin G. Haza
Assistant Vice President

110 East Washington Street
Indianapolis, Indiana 46204
Phone (317) 631-1311

Indianapolis

**Morris
Plan**

Brief Summary of Prescribing Information Combined TEGOPEN® (cloxacillin sodium) Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q. 6h.

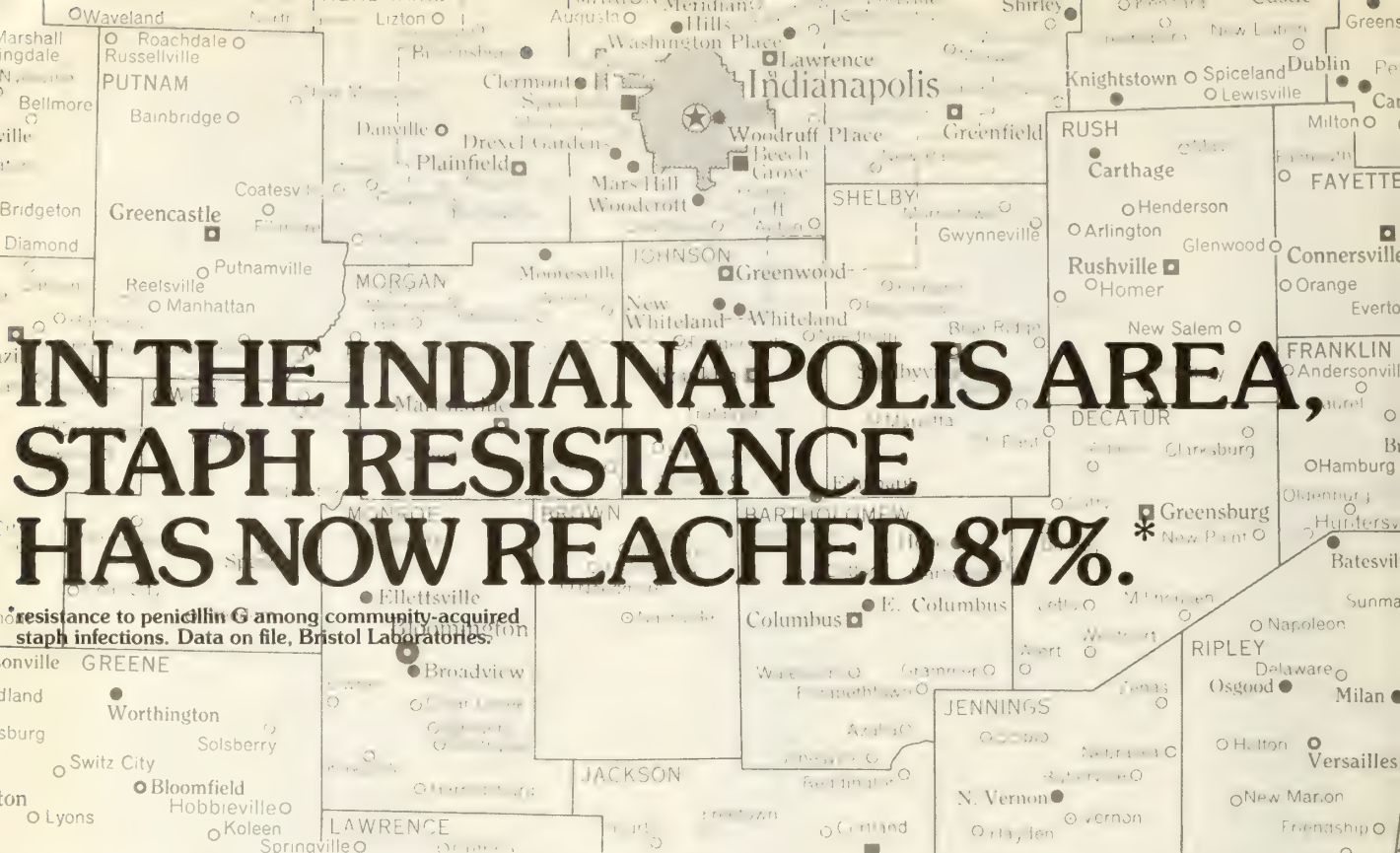
Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

TEGOPEN[®]

(cloxacillin sodium)

...THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *In vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary
for prescribing information.

WILLIAM M. DUGAN, JR., M.D.
Board of Directors
American Cancer Society

New information from
Indiana Division
American Cancer Society, Inc.
2702 East 55th Place
Indianapolis 46220

CANCER CORNER

**EVERY PHYSICIAN'S OFFICE—
A CANCER DETECTION CENTER**

The National Commission on Smoking and Public Policy reported to the American Cancer Society Board of Directors at its meeting Jan. 31, 1978, that the tobacco industry was "virtually unregulated and unaccountable to any department or government agency for the content of its products or the health consequences of their use." The independent Commission, initiated by the American Cancer Society, proposed a program of regulation, education and accountability whose primary goal would be to cut down the toll of more than 250,000 cigarette smoking related deaths annually.

The recommendations were based in part on testimony received from more than 300 citizens from all 50 states during eight Regional Forums held across the country from March through June 1977. Dr. Laurence Bates, medical oncologist, Indianapolis, and author of "Bates Anti-Smoking Buttons;" and Eugene Levitt, Ph.D., director, Section of Psychology and Professor of Clinical Psychology, Indiana University Medical Center, testified at the Regional Forum in Chicago. The Commission included three Nobel prize laureates and top experts in medicine, public health, business and community affairs. They examined data from federal and state agencies, the Library of Congress and reports filed with the Securities and Exchange Commission by the six major tobacco producing companies.

Entitled "A National Dilemma: Cigarette Smoking OR The Health of Americans," the report declares that "a major federal initiative is required to reduce the toll of premature death and suffering related to cigarette smoking, to protect individuals from the risks associated with smoking and to help slow the rapid rise of medical and hospital costs."

Besides its proposals for federal action on the smoking and health problem, the Commission calls upon local governments, schools and voluntary health agencies, including the American Cancer Society, to mount new programs or improve existing efforts.

All recommendations (including those for stringent prohibitions on the tobacco industry and restrictions on advertising in all media) were given serious consideration by the Commission. We concluded, as members of a free society, we should recognize the rights of informed adults to smoke if they choose, because to suggest otherwise would be to imply a prohibition, which is neither enforceable nor desirable in a democratic society.

In selling to adults, the Commission declared, "The cigarette industry has the responsibility not to misrepresent, or to obscure the hazards or seduce the public through advertising imagery."

The Commission noted that despite the federal government's own findings and warnings about the hazards of cigarette smoking, it has done little about it.

Some of the Commission's key proposals call for:

- A phase out over a 10 year period of the present tobacco price support systems.
- The Department of Health, Education, and Welfare to prepare a large scale, paid anti-smoking campaign for all media in cooperation with the major voluntary health agencies.
- The Food and Drug Administration to study the potential harmful additives now being used in many of the newer cigarettes.
- The FDA to seek to bar advertising of cigarettes with more than 10 mg. tar and 0.7 mg. nicotine.
- Insurance companies to be urged to reduce rates for non-smokers.
- A ban on the sale of cigarettes to minors to be strictly enforced.
- Replacing the federal cigarette excise tax with an increased, graduated, uniform tax based on tar/nicotine content.
- A voluntary agreement between the Federal Trade Commission and the tobacco industry to eliminate the use of live models in all advertising.
- State and local governments to prohibit smoking in most public places . . . and to promote separation of smokers and non-smokers in such places as restaurants, trains and buses.
- The banning of smoking in public schools by either students or teachers.
- The American Cancer Society to step-up anti-smoking activity on many fronts, including legislation, education and information.

In a brief review of the Commission's findings, the report describes cigarette smoking related health hazards as being implicated in 80% of lung cancer and emphysema; is a major factor in most cases of oral cancer and cancers of the larynx, pharynx, and bladder; and represents a major hazard for women who use oral contraceptives.

"The ledger of profits and losses from cigarette smoking is unbalanced," it declared, pointing out that while revenue from tobacco products in 1976 totalled about \$12 billion, the habit ". . . cost smokers, their families and society \$18 billion in medical and hospital bills and lost wages—a net loss of \$6 billion."

Although more cigarettes are being consumed than ever before, the report says that fewer adults are smoking. About 65% of adults do not smoke. "More ciga-

CONTINUED ON PAGE 861

65 Miles from Indianapolis, there's a fabulous residential resort called The Pointe.

You can call it home.



You're lucky. Living in Indiana puts you within comfortable weekending distance of a world of recreational and residential pleasure other people can only visit on special occasions.

Your special occasions can happen 52 times a year. When you can enjoy a world of beauty and recreation overlooking 22,000 acres of shimmering lake, set amid the hills and woodlands of Hoosier National Forest. It's a resort world, complete with every facility, from yacht club and marina to restaurant and lounge. Beaches, boating, fishing. Living.

It's a private world of community recreation. The Pointe's own PGA championship golf course, swimming pool, tennis courts, gourmet dining and conviviality in the clubhouse's restaurant and lounge.

And a residential world — an almost endless variety of holiday and full-time homes. Comfortable one-bedroom vacation homes to year-round family homes up to 3 bedrooms. From as little as \$29,990 to \$79,990. Four distinctive communities, each with its own variety of designs.

Discover it for yourself. Call (812) 824-7022, collect. Or drive out SR-37 South to the Harrodsburg exit and follow the signs. Models are open 10 till 7 daily. Start living a full-time vacation.



The Pointe on Lake Monroe

FUTURE FILE

University of Illinois CME Seminar

The "Midwest Symposium on Affective Disorders/Depression Update: Diagnosis and Management in Everyday Practice" will be the subject of a continuing medical education seminar conducted by the University of Illinois Oct. 5 - 6 at the Holiday Inn-Chicago City Centre. AMA Category I Credit: 12 hours. The program is designed for primary care practitioners. For further information write Office of Continuing Education Services, 1853 W. Polk St., Room 144, Chicago 60612.

Three-Day Cancer Symposium

Highlands Baptist Hospital and the Highlands Baptist Medical Oncology Unit will present a three-day cancer symposium entitled "Topics in Medical Oncology" Oct. 4-6. Day One deals with anticipatory grief; Day Two is a series of lectures by visiting physicians; and Day Three is directed to the nurse working with cancer patients and their families. Contact Pat Strait, Symposium Coordinator, 810 Barret Ave., Louisville, Ky. 40204—Tel: (502) 583-4841, Ext. 432.

Polytomography of the Temporal Bone

The 19th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otolaryngology at Community Hospital, Indianapolis, September 23-24. As an organization accredited for continuing medical education, the Wright Institute of Otolaryngology, Inc. certifies that this continuing medical education activity meets the criteria for 12 credit hours in Category 1 of the Physician's Recognition Award of the AMA.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Fee for the course is \$250. Inquiries should be directed to:

The Wright Institute of Otolaryngology, Inc.
Community Hospital of Indianapolis
1500 North Ritter Avenue
Indianapolis 46219

Hair Transplant Symposium

The annual hair transplant symposium and workshop will be held in Hot Springs, Ark., Jan. 25-27, 1979. It is sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, Inc., and endorsed by the American Society for Dermatologic Surgery. Registration fee is \$720. For further information, contact Dr. D. B. Stough, III, Program Director, Doctors Park, Hot Springs, Ark. 71901.

Michigan CME Offerings

The following courses are sponsored by the University of Michigan Medical School and meet criteria for Category I credit. For further information, contact the university's Department of Postgraduate Medicine and Health Professions Education, The Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48109.

Oct. 16-20: "Family Practice Review," for family physicians.

Oct. 25: "Short Term Psychotherapy," for psychiatrists and psychotherapists.

St. Mary's Offers Two Seminars

The following two seminars are being offered by St. Mary's Medical Center, Evansville. Both programs have been approved for Category 1 credit for the Physicians Recognition Award and for prescribed credit by the American Academy of Family Physicians. For more information, contact W. Thomas Spain, M.D., Director of Medical Education, St. Mary's Medical Center, 3700 Washington Ave., Evansville, Ind. 47750.

MacKenzie Seminar—"The Infertile Couple"—Sept. 14
Moderator: Hugh A. Stallings, M.D.

- 1:00-2:00 The Couple as a Unit—Emery Wilson, M.D.
- 2:00-3:00 Ovulation—H. Oliver Williamson, M.D.
- 3:00-3:15 Break
- 3:15-4:15 Cervical Seminal Factors—Robert Cleary, M.D.
- 4:15-5:00 Induction of Ovulation—C. D. Christian, M.D.
- 5:00- Management of Difficult Patients—Panel Discussion
Adjournment

Critical Care Seminar—Sept. 28

- 10:00 a.m. Overview: Why Critical Care Units
Robert F. Wilson, M.D., Wayne State University
- 10:10 a.m. Pulmonary Needs in Critical Care
James Fattu, M.D., St. Mary's Medical Center
- 11:00 a.m. Heart Stresses in Critical Care
Donald Rothbaum, M.D., St. Vincent Hospital
- Noon Lunch
- 1:00 p.m. Pediatric Critical Care
Paul T. McEnery, M.D., University of Cincinnati
- 2:00 p.m. Critical Care for Surgical Patients
Robert F. Wilson, M.D.
- 3:00 p.m. Break
- 3:15 p.m. Role of the Nurse in Critical Care Units
Jacqueline Wilson, R.N., M.S., Wayne
- 3:45 p.m. The Emerging Specialty of Critical Care Medicine
Robert L. Iverson, M.D., Methodist Hospital
- 4:30 p.m. Future Promise of Critical Care
Guest Speakers

A large, thick, black L-shaped graphic that serves as a background element. It starts at the top left, goes right, then down, and finally turns into an arrow pointing towards the bottom right corner.

COMPUTER?

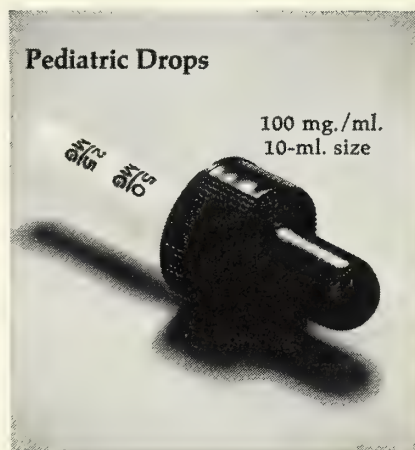
BEFORE YOU MAKE A DECISION
TALK TO A SPECIALIST.

GENERAL MICROCOMPUTER

COST EFFECTIVE
MICROCOMPUTER SYSTEMS
TAILORED TO THE SPECIFIC
NEEDS OF YOUR PRACTICE

GENERAL MICROCOMPUTER, INC.
1657 COMMERCE DRIVE
SOUTH BEND, INDIANA 46628
(219)-233-9171

easy to take



Keflex®
cephalexin



500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206



"...Sleep that knits up the ravel'd sleeve of care..."

—WILLIAM SHAKESPEARE, *MACBETH* (ACT II, SCENE I)

Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime! Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdose.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

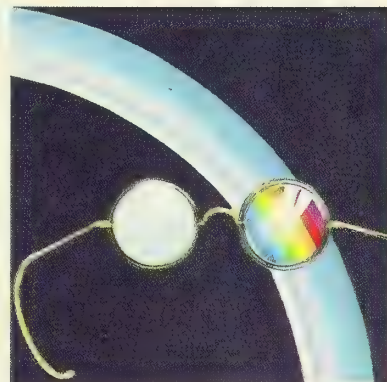
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life
in shades of blue...
help them see life
in all its colors.

Adapin®

(doxepin HCl)

single daily dose recommended h.s.



10 mg capsules



25 mg capsules



50 mg capsules



NEW 100 mg capsules

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

100 mg

250 mg

500 mg



Tolinase[®]

tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

© 1977 THE UPJOHN COMPANY

BOOK REVIEWS



Radiologic Chart of the Human Skeleton

Birkner, 1978, Urban & Schwarzenberg, 7 E. Redwood St., Baltimore, Md. 21202, \$25.

The radiologic chart of the human skeleton is a large composite, schematic representation which is 3/5 life size, suitable for hanging on the office wall. It is well constructed, and the anatomic delineation is excellent. A detailed skeletal chart is a necessity in a teaching environment, either for under-graduates or in any of the orthopedic, radiologic or neurologic residency programs.

Around the margins of the chart are listed

identifications of normal variants, anomalies and borderline abnormalities. In addition, charts of bone age, supernumery ossicles and color coding of unusual sites of fractures and apophyseal abnormalities are listed.

This type of chart is rarely available in this size with the detail which is present, and I believe it will be a very desirable addition to most radiology departments.

JOHN W. BEELER, M.D.
Radiologist
Indianapolis

Atlas of Radiologic Anatomy

Lothar Wicke, 1978, Urban & Schwarzenberg, 7 E. Redwood St., Baltimore, Md. 21202, 117 radiographs, 118 line drawings, 234 pages, \$15.

This book perpetuates the long tradition of anatomic-radiologic correlation at the University of Vienna Institute of Anatomy. The atlas presents more than a hundred excellent radiographs, with explanatory diagrams on the page opposite each. The explanatory line drawings greatly enhance the value of the radiographs. The selection encompasses skeletal radiography of limited special areas and

also covers the essential aspects of roentgen anatomy in all parts of the body.

Although the nomenclature employed is that of the *Nomina Anatomica*, it also includes commonly used medical terms so that students can become quickly familiar with both.

The book contains a subject index, Latin-to-English and English-to-Latin. The book's nature is such that it should be useful to virtually any physician.

W. D. SNIVELY, JR., M.D.
Internal Medicine
Evansville

INDIANA MEDICAL BUREAU

1010 East 86th St.—72 Winterton

Indianapolis 46240

844-7933

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 26th Year of Service

BOOK REVIEWS

Mealtime Manual for People with Disabilities and the Aging

Compiled by Judith L. Klinger, O.T.R., M.A., with the Institute of Rehabilitation Medicine, New York University Medical Center and the Campbell Soup Company, 2nd edition, 1978, 267 pages spiral-bound, \$3.25. For copies write "Mealtime Manual," Box 38, Ronks, Pa. 17572.

"Mealtime Manual," which includes 17 pages of references and agencies and 12 pages of index, features illustrations over half of its pages, with occasional diagrams. In a notable foreword by Howard A. Rusk, M.D., the reader is reminded of a legend that "an old man will starve to death if he doesn't have someone to cook for him, and an old woman will starve to death if she doesn't have someone to cook for . . . If it is true for the aged, it is doubly true for the disabled."

This manual is as practical an approach to the problems encountered as one could hope to find, and contains many homemaking hints that could brighten the chores of housekeeping for the young and the perfectly healthy, intact individual. A partial list of the table of contents will give some idea of the thoroughness so evident in this book:

Hints for the Homemaker Who Works With One Hand . . . With Weakness in the Upper Extremities . . . With Arthritis . . . With Incoordination . . . Who Uses a Cane, Crutches, Walker or Other Ambulation Aid . . . Who Uses a Wheelchair . . . Hints for the Upper-Extremity Amputee . . . Included is the homemaker with lowered energy levels, loss of

sensation, or loss of vision. It also includes hints for older people and for those who are alone.

There is much on kitchen planning and storage, selection of kitchen tools and safety in kitchen and home. The outstanding hallmark of excellence and practicality is the wealth of information explaining special gadgets for conquering all sorts of kitchen problems together with exact data as to the names of the gadgets, who makes them and where they may be obtained.

Then there are sections on nutrition and menu planning, shopping, convenience foods, and a "metric primer," leading finally to the recipe section, which includes techniques for handling containers, measuring, peeling, cutting, mixing, chopping, pouring, range-top cooking, baking, garnishing and serving. Just imagine one particular disability listed above in boldface—for instance, working with only one hand—and try to figure how you would manage the functions thus quoted. This book contains solutions for all these difficulties, derived from long experience in rehabilitation as well as from "research."

This work stems, of course, from the need to help those with permanent handicaps from conditions such as polio, amputation, arthritis, etc., but physicians are also confronted with patients having a temporary handicap, such as Colles fracture, who could benefit greatly from the use of this manual.

A. W. CAVINS, M.D.
Gynecologist
Terre Haute



McClain Car Leasing, Inc.

1745 Brown St., Anderson, Ind.

Phone 317/642-0261

Specializing in Professional Car Leasing

ALL MAKES AND MODELS AVAILABLE

We are proud to offer a Leasing Plan approved by ISMA

NEWS NOTES

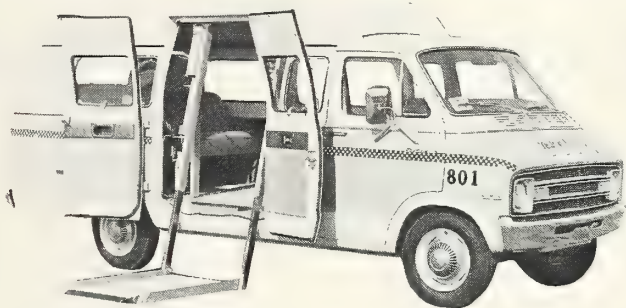
Physician Recognition Awards

The following Indiana physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Barnes, Gilbert Harvey, Carmel
Biegel, Angenieta Anne, Indianapolis
Bilodeau, Richard Gerrard, Tipton
Blackburn, Howard R., Noblesville
Brincko, John, Gary
Brown, Earl Robert, Indianapolis
Cobb, Clarence M., Indianapolis
Comeau, William Joseph, Marion
Gartner, Jose C., Jasper
Garvish, John Franklin, Crawfordsville

Gastineau, David C., Ft. Wayne
Glanzman, Norman, Carmel
Glendening, Richard L., Logansport
Hazelrigg, Donald Edwin, Evansville
Jardenil, Romulo S., Kentland
Lampton, Lawrence Marcus, Indianapolis
Macy, Warren Lee, Greencastle
Mason, Donald Gooding, Angola
Mason, Earl James, Gary
McCarthy, Leo Joseph, Indianapolis

Moss, Herschel C., Indianapolis
Roggenkamp, Milton W., West Lafayette
Roig, Jose Huge, Merrillville
Saperstein, Morris, Noblesville
Shah, Tarunbala Navin, West Lafayette
Stadler, Harold F., Indianapolis
Webb, Orville Lynn, New Castle
Welk, Gordon Daniel, Rossville
Whitfield, James E., Kokomo

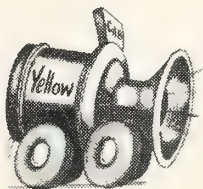


LET US GIVE YOU A LIFT...

Yellow Medi-Car service is now available to all persons confined to a wheel chair. If a person is ill, handicapped, physically limited or aged and must use a wheel chair, the new non-scheduled van service of Yellow Medi-Car is available with prior notice or by 24 hour reservation. These new modern vans with a level, hydraulic lift can be used to transport wheel chair passengers to work, shopping, visit relatives and friends, obtain medical treatment or medicine, and to attend church and recreational events.

SERVICE AREAS:

Indianapolis and Marion,
Boone, Madison, Hamilton,
Hendricks, Johnson, Morgan,
Hancock and Shelby Counties.



Yellow Medi-Car

FOR FURTHER INFORMATION
CALL 637-5421
WE MAKE
HOUSE CALLS!!

Where people come first

NEWS NOTES



"DO YOU REALIZE, YOU HAVE ME BOOKED UP
FOR THE REST OF MY LIFE?"

'Duke's Day' a Financial Success

Duke's Day occurs once a year in Fort Wayne and has done so for nine years. It is a day devoted to a social and professional meeting of physicians, dentists, pharmaceutical representatives and pharmacists. The main program includes golf, trap and skeet, road races, horse shoe pitching, tennis and table tennis. The principal side effect and one of the main purposes of the program is the maintenance of scholarships for paramedical and paradecimal students of the Fort Wayne area. To date, 203 scholarships have been awarded for an eight-year total of \$50,750. The 1978 event was financially successful enough to prompt the organization to either increase the number of scholarships or increase the amount awarded.

Ultrasound Breast Cancer Device

An ultrasound breast scanning device, the first of its type to be used in the United States, is being installed at the I.U. Medical Center by the Indianapolis Center for Advanced Research. The promising diagnostic instrument is seen by medical experts as an important step in detection of breast cancer and other changes in tissue culture. The scanning tool is being assembled at the I.U. Medical Center under the direction of Dr. Elizabeth Kelly Fry, a research scientist at ICFAR and an associate professor at the I.U. School of Medicine. Dr. Fry has directed ICFAR's ultrasound program in breast cancer since 1972. Ultrasound techniques are expected to take on growing importance in breast cancer detection since the National Cancer Institute recently recommended that x-ray mammography not be used as a screening device for women under 50 years of age.

New Orleans Assembly Plans Meeting

The New Orleans Graduate Medical Assembly has announced its 1979 meeting for April 27 through May 1, 1979. It will meet at the Fairmont Hotel in New Orleans. The theme will be "Management of Common Problems in Office Practice—Update." More details will be published later or may be obtained by writing Lois Neary, 1430 Tulane Ave., New Orleans, La. 70112.

Certificate of Need Assistance

A new Certificate of Need Assistance Program has been formed by Pfizer Pharmaceuticals and Diagnostic Products. Dr. Sheldon Gilgore, president of Pfizer, says that a toll-free telephone consultation service is available to hospital administrators and the hospital community. It will furnish expert consultation on the medical needs and cost effectiveness of major diagnostic equipment, and the relevance of this information to Certificate of Need. Pfizer also provides a complimentary copy of a book "Certificate of Need: An Expanding Regulatory Concept" to the hospital administrator. The 944-page book is a comprehensive, state compilation of Certificate of Need requirements. The free consultation service may be reached from 9 to 5 Monday through Friday by dialing toll-free 800-638-9690.

HELP FOR THE CONGENITALLY HANDICAPPED CHILD

It wasn't so long ago that congenitally handicapped children were allowed to reach school age or even later before being fitted with a prosthesis. In recent years, experience has shown that fitting at an earlier age produces more effective results—both mentally as well as physically. HANGER provides individually designed prostheses to give aid to the congenitally handicapped child. Children with "HANGER PROSTHESES" can live normal lives. Using their HANGER appliances they exercise freely, ride bicycles, roller skate, play basketball, tennis, and engage in most of the activities like other growing children. These activities enable the child to become self-reliant. Each HANGER prosthesis follows much the same design as those for the adult, but utilizes specially developed components of appropriate size, thus providing a smoother transition as the child grows into adulthood. HANGER also provides devices and techniques for the initial fitting of infants and problem cases. Training of children in the use of their prosthesis is highly desirable, even though children present some problems not seen in adults. Since the attention span of young children is short, extreme patience is required. Some handicaps make an ideal gait-pattern difficult if not virtually impossible to achieve. It should be noted that complete cooperation of the parent is necessary regardless of the experience and ability of the therapist. (Often the parents pass on a sense of guilt that is completely unfounded as there are no known preventive methods to combat the problem of a congenital handicap.)

Hanger
PROSTHESES

1332 N. Illinois St., Indianapolis, Indiana 46202
312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

NEWS NOTES

Treatment of Menopausal Women

Professor Richard Landau, editor of *Perspectives in Biology and Medicine* and a distinguished endocrinologist, has written a critique on the clinical problems of estrogen treatment of menopausal women. The article encompasses the science, the medicine, and the politics of estrogen prescribing. Copies may be obtained by writing the Center for the Study of Drug Development, 601 Elmwood Ave., Rochester, N.Y. 14642.

Cardiac Film Offered

A film designed to help health professionals run courses in advanced cardiac life support has been produced by HEW in cooperation with the American Heart Association. To borrow the 30-minute color 16mm film or 3/4" videocassette, write to the National Medical Audiovisual Center (Annex), Station K, Atlanta, Ga. 30324.

Diet Information for 25¢

"Guide to Wise Food Choices" is an attractive and colorful eight-page booklet that outlines and explains the basic rules for a nutritious diet. Intended for the general public, it is obtainable from local Dairy Councils or, for 25¢, from the National Dairy Council, 6300 N. River Road, Rosemont, Ill. 60018.

Certification Statement Out

Blue Cross/Blue Shield has received approval from the State Department of Public Welfare to accept physicians' orders, medical evaluations, referral/transfer forms, and admission review forms—all of which must be signed and dated—in lieu of a specific certification statement. The action came as a result of a reconsideration by SDPW concerning the issue of Medicaid Physician Certification in Hospitals.

Hoosiers Elected to AMA Positions

Two Indiana delegates to the AMA were elected to AMA councils during June's annual meeting. They are Dr. Malcolm O. Scamahorn, Pittsboro, Council on Medical Service; and Dr. Peter R. Petrich, Attica, Council on Constitution and Bylaws. Dr. Lowell H. Steen, Hammond, was named to the AMA Board of Trustees' Executive Committee.

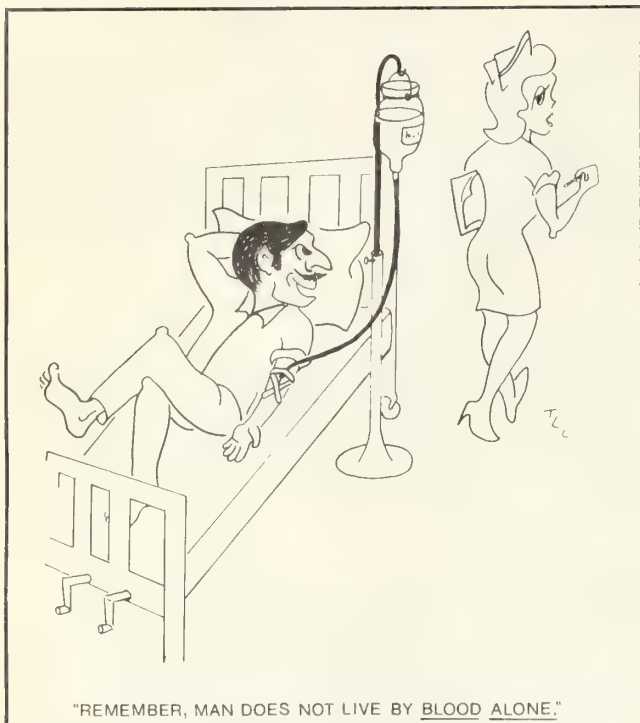
Jogging Clinic Conducted

Dr. Daniel J. Combs of Vincennes served as instructor earlier this summer for a three-part jogging clinic conducted by the Vincennes YMCA. He discussed basic cardiovascular physiology, fitness requirements, contribution of other forms of exercise and sports to total fitness, basic mechanics of running, muscle and joint physiology, and how to start a running program.

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Southern Indiana Office: Kenneth W. Moeller, Representative
1810 Broad Ripple Avenue Telephone: (317) 255-6525
Mailing Address: P.O. Box 20132, Indianapolis 46220
Northern Indiana Office: Douglas O. Sellon, Representative
120 LaSalle West Bldg., Suite 304
South Bend, In. 46601 Telephone: (219) 289-7332

NEWS NOTES



How to Prevent Home Fires

"Fire in Your Home: How to Prevent It. How to Survive It" is the title of a 56-page, full-color, illustrated paperback book released by the National Fire Protection Association. It is a guide on fire prevention, detection and survival. It is for sale for \$1.75, with discounts for quantity. The address is 470 Atlantic Ave., Boston 02210.

Merritts Off to Washington

Dr. A. Donald Merritt, professor and chairman of the Department of Medical Genetics, and his wife Dr. Doris E. Merritt, dean of the Office of Research and Sponsored Programs at Indiana University School of Medicine, have both been placed on special assignment to work with the National Institutes of Health during the coming year.

Emergency Medical Identification

Increasingly, hospitals are providing emergency care to patients with whom they have had no previous contact. Often, patients are unconscious or close to it and therefore are unable to relate their hidden medical conditions. The solution is for the patient to wear a Medic Alert bracelet or necklace that features an engraved telephone number. The physician can call the number, give the indicated patient ID number, and obtain a list of current medication, and the name and phone number of the patient's private physician. Although there are numerous emergency medical ID systems, some physicians in Indiana may not know that the non-profit Medic Alert Foundation has a regional office in Chicago. Medic Alert, endorsed by the American Hospital Association, offers professional education materials and application forms at no cost. For more information, write them at 840 N. Lake Shore Drive, Chicago 60611.

Diabetes Research Award Announced

The Juvenile Diabetes Foundation, 23 East 25 St., New York City 10010, has announced a career development award in Diabetes Research for the year beginning July 1, 1979. Applications must be postmarked not later than Oct. 1, 1978. Candidates must have a doctoral degree with approximately four to seven years postdoctoral clinical and/or research experience by the beginning of the award. The award has a three-year term with annual review. Salary for one year is up to \$35,000.

FOR SALE

ALBANY, INDIANA—Retiring medical doctor's residence and office. Established 50-year general practice. Located in town of 2,500 population with growing community. Situated within 12 miles of all modern hospital. A beautiful 2-story home with 9 rooms, fully carpeted down with hardwood floors up. Formal dining room, family room, living room, kitchen with glassed in breakfast room, 2 ceramic baths, all nicely decorated. Full basement with doctor's office, 3 finished rooms with separate entrance and garage. Gas heat with central air. Also a 2-car garage with electric opener. Nice fenced in yard with trees. TOM D. FLESHER, REALTOR—205 West State Street, Albany, Indiana 47320. Phone (317) 789-6162.





AS I SEE IT

David M. Harvey, M.D.
Representative
1st Congressional District, Indiana



The purpose of this regular feature is to provide IMPAC board members an opportunity to express their views on the political issue of their choosing.

The First Congressional District of Indiana encompasses most of the northern half of Lake County. Congressman Adam Benjamin of Hobart represents Lake County in Washington and Mrs. Bonnie Egnatz and I represent the First Congressional District in IMPAC. For many years the First Congressional District was represented by Congressman Ray Madden, also a Democrat, but two years ago, with the help of IMPAC, Mr. Benjamin successfully challenged Mr. Madden.

Mr. Benjamin had established his reputation as a hardworking, dedicated, fair-minded state senator. He was the "prime mover" in the writing and passage of Indiana's landmark malpractice legislation. In the 18 months that he has been in Congress he has continued to build on his reputation as a legislator.

The members of the Indiana Medical Political Action Committee are justifiably proud of the part they have played in the political process in our state. It is only by being actively involved in supporting able, conscientious candidates

who support the views of "organized medicine" that we can hope to stem the tide of further government interference in the practice of medicine.

While previously confining its efforts to the gubernatorial and congressional races, the Board of IMPAC has recognized that state legislative campaigns should not be ignored. For that reason, the Board has begun to analyze campaigns, seeking out key races where there is a clear difference in the candidates and where our support will improve "our" candidate's chance of success.

The function of the IMPAC Board is important in that it allows Medicine to assist those candidates with hard campaign dollars when they need them most. The Board, of course, cannot function in any meaningful way without the continued support of our membership throughout the state. In addition to each of us becoming personally involved in the campaigns and issues at our local level, it is vital that our own personal membership in IMPAC continue so that the Board may effectively do its work. If you are not now a member, a \$50 check will make you a part of Medicine's voice in the legislative process.

Cancer Corner . . .

CONTINUED FROM PAGE 847

rettes are being consumed, however, by those who do smoke, and teenagers, especially young women, constitute a higher percentage of smokers than ever before."

In the face of a decade of scientific evidence that cigarette smoking is unhealthy, "Congress has specifically exempted cigarettes and other tobacco products from any regulation or control by the Consumer Products Safety Commission or the Environmental Protection Agency."

The cigarette industry spends \$422 million annually on advertising as opposed to a budget of \$55,000 of the National Interagency Council on Smoking and Health.

Prior to 1976, because of Federal limitations on legislative activities by non-profit organizations . . . "none of the major voluntary health agencies" . . . has been involved to the degree necessary in effective public policy or legislative activities, consumer protection efforts, or promotion of the rights of non-smokers. "This has allowed the industry's lobbying efforts to go virtually unchallenged in the vital areas," the report declared.

There is a great need for research ". . . to find out why people smoke and what makes them quit."

And finally, "based on all the data available to us, we do not believe there is a 'safe' cigarette, and we urge that no responsible individual or organization use that term," the report declared.

NEW increased limits under ISMA sponsored income protection plan

33⅓% more in fact! You can now provide yourself monthly income disability protection up to \$2,000 from the previous limit of \$1,500 (subject to a participation of \$3,500 per month with other companies) if you are disabled and unable to work due to an accident or illness.

OTHER INSURANCE PLANS AVAILABLE

In addition to this disability income protection that now helps you replace more of your earned income when you cannot work, there are four other Association sponsored supplemental insurance plans. You, as an ISMA member physician or professional corporation are eligible to add to your protection through these supplemental plans.

- **EXCESS MAJOR MEDICAL PLAN** provides coverage after your present plan is exhausted. Up to \$250,000 coverage and two deductibles available (\$15,000 or \$25,000). Unlimited surgical schedule and includes extended care and nursing home benefit.
- **OVERHEAD EXPENSE PLAN** provides needed dollars to help you pay off overhead expenses (employees' salaries, rent, utilities, property taxes, etc.) in the event of your disability. When disability strikes — your business overhead expenses keep right on going — even when you can't.
- **FAMILY LIFE INSURANCE PLAN** provides benefits up to \$60,000 in the event of your death.

ALL PLANS ARE ALSO AVAILABLE FOR PROFESSIONAL CORPORATIONS

COUPON

For information on the ISMA sponsored

- ☐ Income Protection Plan
☐ Excess Major Medical Plan

- ☐ Overhead Expense Plan
☐ Family Life Insurance Plan

☐ Professional Corporation

Administered by

Dr. _____

Street _____

City _____ Zip _____



j. russell townsend and associates

Mail to:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

COMMERCIAL ANNOUNCEMENTS

Commercial announcements are carried in The Journal as a special service to ISMA members. Only advertisements considered by publisher to be of advantage to members will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

20¢ for each word

\$4.00 minimum

Send cash with order. Average count: seven words to the line.

Address: The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

DEADLINE: Fifth day of month PRECEDING month of issue.

OPPORTUNITIES FOR PHYSICIANS—There are several excellent openings among the Indiana State Hospitals at various locations throughout the State for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Candidates must be licensable in Indiana. Please reply with a copy of the c.v. to: FARABEE & ASSOCIATES, INC., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

PHYSICIAN'S OFFICE AVAILABLE—Has been physician's office for last 8 years. Eastside, 5 minutes from St. Francis and Community Hospitals. All utilities except phone. American alarm, private parking, large waiting room. (317) 357-7657 or 357-2403.

EXCELLENT OPPORTUNITY—Physician—for Disability Determination Division, Indiana Rehabilitation Services. No insurance requirements, no patient load, low-pressure atmosphere, excellent fringe benefits. Contact the Personnel Officer, 1-317-633-6828, or write above agency at Room 1010 Illinois Bldg., 17 W. Market St., Indianapolis 46204.

EMERGENCY ROOM PHYSICIAN—Full-time position in 365-bed hospital. \$48,000 guaranteed minimum. Contact Ralph D. Weller, M.D., Emergency Department, or Mr. Duane R. Vorseth, associate administrator, Lafayette Home Hospital, Inc., 2400 South St., Lafayette, Ind. 47904. (317) 447-6811.

OPHTHALMOLOGIST—Board certified/eligible ophthalmologist sought to associate in an established practice. Major regional medical center consisting of 43 multi-specialty physicians in northwest Ohio. Top salary and excellent fringe benefit program along with all corporate benefits. Please forward curriculum vitae, salary requirements to Box J, The Journal.

EXECUTIVE DIRECTOR—Immediate opening for an experienced individual to assume management of medical peer review organization. Candidate must possess management, administrative, public relations and public speaking skills. The ability to relate to medical/political oriented environment essential. A thorough knowledge of health care administration, physician peer review mechanism and Medicare/Medicaid regulations required. Background should also include experience with finance, computer systems and health insurance. A degree and/or more than five years experience in health-related fields required. Please send resume to: Indiana Area V PSRO, 9247 N. Meridian St., Suite 330, Indianapolis, Ind. 46260.

THE INDIANA STATE DEPARTMENT OF PUBLIC WELFARE has a position available for a physician to work in a pleasant office atmosphere; no patient contact; no malpractice insurance required; an Indiana license or eligibility is required; competitive salary; regular working hours; excellent fringe benefits. Contact: Personnel Director, Indiana State Department of Public Welfare, 702 State Office Building, 100 N. Senate Ave., Indianapolis 46204. Phone: (317) 633-6403.

RETIRED or physically restricted or limited practice physicians as MEDICAL DIRECTORS of plasma center in West Lafayette area. Call Mr. Reiland at (317) 924-6336, PLASCON, INC.

EMERGENCY MEDICINE: Seeking career-oriented emergency physician to complete group of four. Community hospital with 330 beds and 30,000 emergency department visits per year. Malpractice insurance provided. Fee for service compensation. Contact Paul Laudick, St. John's Hospital, 2015 Jackson St., Anderson, Ind. 46014.

MEDICAL DIRECTOR NEEDED—Indiana Area III PSRO, Inc., is looking for a physician to direct peer review activities for our quality assurance program on a half-time basis. Knowledge of PSRO, peer review and utilization review helpful but not essential. Education and fringe benefits available. If interested, please contact Executive Director, Indiana Area III PSRO, Inc., 310 Medical Center Building, Fort Wayne, Ind. 46802.

IMMEDIATE, EXCELLENT OPENING FOR FAMILY PHYSICIAN—Well-established practice left in July by a deceased physician; fine, well equipped building available for very reasonable rent. Located in New Palestine, Ind., near Indianapolis. The community could easily support two family physicians who would enjoy the fine schools, churches and very favorable economic climate. This opportunity combines the advantages of a growing, progressive community with easy access to Indianapolis for additional social and cultural activities. Hancock Memorial Hospital is only minutes away. It is a fully accredited hospital with a family practice orientation that is well served by visiting specialists from Indianapolis. Contact John B. White, administrator, Hancock County Memorial Hospital, Box 827, Greenfield, Ind. 46140. (317) 462-5544.

EMERGENCY DEPARTMENT DIRECTOR NEEDED—Modern community hospital with excellent work surroundings, near Cincinnati. 17,000-20,000 patient visits per year. Annual salary and benefits total from \$66,000-\$68,000. Some residency training and administrative experience helpful, but not necessary. Interested parties should call collect Dr. G. T. Bowen, M.D., Dearborn County Hospital, Lawrenceburg, Ind. 47025. (812) 538-1010.

Announcing

INDIANA STATE MEDICAL ASSOCIATION
(Founded in 1849)



129th Annual Convention



October 22-25, 1978

Marriott Inn

and

**Kentuckiana Convention and Sports Center
Clarksville, Indiana**

INSIDE:
SCHEDULE OF EVENTS
GUEST SPEAKERS
EXHIBITS
ANNUAL REPORTS
RESOLUTIONS

All Events on Eastern Standard Time

CONVENTION SECTION

Table of Contents

OFFICIAL CALL TO THE HOUSE OF DELEGATES	866	Medical Education	907
HOUSE OF DELEGATES	867	Public Relations	909
1977-78 ISMA OFFICERS:		Constitutions and Bylaws	910
Officers	872	Legislation	912
Trustees	874	REPORTS OF COMMITTEES:	
Alternate Trustees	875	Future Planning	914
Delegates (and Alternates) to AMA	876	Grievance	914
Medical Staff—The Journal	877	Medical Legal Review	914
Section Officers	878	Medical Education Fund	914
SCHEDULE OF EVENTS	881	Arbitration and Negotiations	915
Auxiliary Program	937	Impaired Physician	916
50-YEAR CLUB—1978	890	REPORTS OF AD HOC COMMITTEES:	
CONVENTION ARRANGEMENTS COMMISSION	890	Improvement of Medical and Health Care in Jails	918
GUEST SPEAKERS	891	Computed Tomography	918
REPORTS OF OFFICERS:		Immunizations	919
Executive Director	895	Data Processing	919
Board of Trustees	896	REPORTS OF TRUSTEES	921
Executive Committee	898	COUNTY MEDICAL SOCIETY DIRECTORY ..	927
Treasurer	899	REFERENCE COMMITTEES	928
AMA Delegation	900	RESOLUTIONS	929
The Journal	905	SCIENTIFIC EXHIBITS	933
REPORTS OF COMMISSIONS:		TECHNICAL EXHIBITS	936
Medical Services	906		

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Marriott Inn, Clarksville, Indiana, October 22, 23, 24 and 25, 1978.

The House of Delegates will be constituted as follows: Marion County, twenty-four delegates; Lake County, ten delegates; Allen County, seven delegates; Vanderburgh County, six delegates; St. Joseph County, five delegates; Delaware-Blackford, Owen-Monroe, Tippecanoe, Vigo and Wayne-Union county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Grant, Harrison-Crawford, Howard, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion and Porter county societies each two delegates; the other 56 county societies, each one delegate; fourteen trustees and the ex-presidents—namely, Herman M. Baker, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Eugene S. Rifner, Patrick J. V. Corcoran, Lowell H. Steen, Malcolm O. Scamahorn, Peter R. Petrich, James H. Gosman, Joe Dukes, Gilbert M. Wilhelmus, Vincent J. Santare and John W. Beeler. The American Medical Student Association, one delegate. The delegate or their designated alternate delegate elected by their respective section shall also be a member without power to vote. The following shall be ex officio members: the president, president-elect, the executive director, the treasurer, the assistant treasurer, the speaker, the vice-speaker and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the speaker or person presiding shall cast the deciding vote.

All delegates must present their credentials card certified by their county medical society before being seated as a delegate. No delegate will be seated without proper certification.

The House of Delegates will convene promptly at 3 p.m., EST, Sunday, October 22, in the Marriott Inn, Clarksville. The final meeting of the House of Delegates will convene at 9 a.m., Wednesday, October 25, in the Marriott Inn.

The order of business will be as follows:

1. Call to order by the President.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House or those who served the Association in an official capacity and who have died since the 1977 session.
6. Reading of minutes of previous meetings.
7. Introduction of guests.
8. President's address.
9. Appointment of Reference Committees and assignment of meeting rooms.

10. Unfinished business.
11. Address of president-elect.
12. Report of president of the ISMA Auxiliary.
13. Report of the Indiana Chapter, American Medical Student Association.
14. Report of president of Blue Shield.
15. Report of executive director.
16. Report of treasurer.
17. Report of chairman of the Board.
 - A. Reports of Actions of the Board of Trustees
18. Report of trustees.
19. Report of The Journal editor.
20. Report of AMA delegates.
21. Report of the Indiana Medical Licensing Board.
22. Ad Hoc Committee to Supervise Pilot Project on Medical and Health Care in Jails.
23. Ad Hoc Data Processing Committee.
24. Ad Hoc Committee on CAT Scanners.
25. Ad Hoc Committee on Immunization.
26. Ad Hoc Committee on Joint Commission on Accreditation of Hospitals.
27. Ad Hoc Committee on Joint Practice Commission on Nurses and Physicians.
28. Reports of committees and commissions.

COMMITTEES

- (1) Executive
- (2) Grievance
- (3) Future Planning
- (4) Medical-Legal
- (5) Arbitration and Negotiations
- (6) Impaired Physician
- (7) Medical Education Fund

COMMISSIONS

- (1) Commission on Constitution and Bylaws
 - (2) Commission on Convention Arrangements
 - (3) Commission on Legislation
 - (4) Commission on Public Relations
 - (5) Commission on Medical Education
 - (6) Commission on Medical Services
29. New Business:
- (1) Matters referred by Board of Trustees
 - (2) Matters referred by Executive Committee
 - (3) Resolutions
 - (4) Selection of city for 1983 meeting
 - 1979—Indianapolis—October 8-10
 - 1980—Indianapolis—dates to be set by the Board of Trustees
 - 1981—Indianapolis—Dates to be set by the Board of Trustees
 - 1982—Indianapolis—dates to be set by the Board of Trustees

(CONTINUED ON PAGE 870)

1978 House of Delegates

COUNTY AND DELEGATES	Alternate Delegates	COUNTY AND DELEGATES	Alternate Delegates
ADAMS (1) Norval S. Rich Decatur	Harold Zwick Decatur	DECATUR (1) Robert Acher Greensburg	Gene Gebele Greensburg
ALLEN-FORT WAYNE (7) William R. Cast Fort Wayne Thomas A. Felger Fort Wayne DeWayne L. Hull Fort Wayne Fred W. Dahling New Haven Marvin E. Priddy Fort Wayne Charles E. Schoenhals Fort Wayne Charles H. Aust Fort Wayne	Robert W. Dettmer Fort Wayne James J. Harris Fort Wayne Alan W. Sidel Fort Wayne David P. Schlueter Fort Wayne Philip C. Schubert Fort Wayne Richard E. Tielker Fort Wayne Harry D. Tunnell Fort Wayne	DE KALB (1) William Bradley Hughes Waterloo	John C. Harvey Auburn
BARTHOLOMEW-BROWN (2) C. David Ryan Columbus Robert M. Siebel Nashville	Lindley L. Gammell Columbus	DELAWARE-BLACKFORD (3) Warren L. Bergwall Muncie Donald W. Hunsberger Montpelier Ross L. Egger Daleville	Larry Cole Yorktown Herbert W. Berner Muncie Serverino T. Sulit Hartford City
BENTON (1) Manuel Scheurich Oxford		DUBOIS (1) Bernard P. Kemper Jasper	Phillip R. Dawkins Jasper
BOONE (1) Paul R. Honan Lebanon	Don W. Boyer Lebanon	ELKHART (2) Willard Krabill Goshen G. Beach Gattman Elkhart	Burton E. Kintner Elkhart John B. Guttman Wakarusa
CARROLL (1) T. Neal Petry Delphi	Stephen C. Mayers Delphi	FAYETTE-FRANKLIN (2) William F. Kerrigan Connersville Perry F. Seal Brookville	John M. Lockhart Connersville Noli C. Guinigundo Brookville
CASS (1) Richard L. Glendening Logansport	Joseph A. Frederick Logansport	FLOYD (1) Everett Bickers Floyd Knobs	Howard A. Pope New Albany
CLARK (1) David Jones Charlestown	William Voskuhl Charlestown	FOUNTAIN-WARREN (2) Max N. Hoffman Covington A. S. Salvo WilliamSPORT	Lowell R. Stephens Covington Carl A. Nelson West Lebanon
CLAY (1) Robert Oehler Brazil	Everett L. Conrad Brazil	FULTON (1) Joseph D. Richardson Rochester	Pedro G. Del Rosario Rochester
CLINTON (1) Lee F. Dupler Frankfort	Charles E. Bush Frankfort	GIBSON (1) Don Pruitt Evansville	William Dye Oakland City
DAVISS-MARTIN (2) Robert H. Rang Washington B. E. Lett Loogootee	H. O. Norton Washington Robert E. Chattin Loogootee	GRANT (2) Robert Brown Marion Herbert Khalouf Marion	Shirley Khalouf Marion Charles R. Kershner Marion
DEARBORN-OHIO (2) Henry W. Conrad Lawrenceburg Gordon Fessler Rising Sun	Ivan T. Lindgren Aurora	GREEN (1) Mathias S. Mount Bloomfield	J. M. Lardizabal Bloomfield
		HAMILTON (1) A. Adrian Lanning Noblesville	Joe R. Lloyd Noblesville
		HANCOCK (1) Ray A. Haas Greenfield	James L. Garrison Cumberland

1978 House of Delegates

COUNTY AND DELEGATES

HARRISON-CRAWFORD (2)

Louis H. Blessinger
Corydon

HENDRICKS (1)

Joseph C. Kerlin
Danville

HENRY (1)

A. J. May
New Castle

HOWARD (2)

Jack W. Higgins
Kokomo
Richard P. Miethke
Kokomo

HUNTINGTON (1)

Richard Wagner
Huntington

JACKSON (1)

Mark M. Bevers
Seymour

JASPER (1)

Kenneth J. Ahler
Rensselaer

JAY (1)

James S. Fitzpatrick
Portland

JEFFERSON-SWITZERLAND (2)

Robert O. Zink
Madison

JENNINGS (1)

James Calli, Sr.
North Vernon

JOHNSON (1)

M. M. Wesemann
Franklin

KNOX (1)

Frederick H. Buehl
Vincennes

KOSCIUSKO (1)

Wymond B. Wilson
Mentone

LA GRANGE (1)

Michael O. Mellinger
La Grange

LAKE (11)

Leonard W. Neal
Munster
Peter E. Gutierrez
Crown Point
Walfred A. Nelson
Gary
William G. Grosso
East Chicago
David E. Ross
Gary

Alternate Delegates

Carl Dillman
Corydon

Eric D. Clark
Danville

Kenneth Hill
New Castle

Barth Wheeler
Huntington

Kenneth E. Bobb
Seymour

Ralph Schenck
Portland

Robert Johnson
Madison

Joseph Young
Greenwood

David W. Haines
Warsaw

Robert J. Bills
Gary
Reginald R. Barton
Gary
John J. Reed
Hobart
Donald H. Rudser
Whiting
Lee H. Trachtenberg
Munster

COUNTY AND DELEGATES

Charles D. Egnatz
Schereville
Thomas C. Tyrrell
Hammond
Nicholas L. Polite
Hammond
Theodore R. Espy
Gary
Thomas A. Gehring
Merrillville

LA PORTE (2)

Peter J. Pilecki
Michigan City
Barbara Backer
La Porte

LAWRENCE (1)

Florian S. Dino
Bedford

MADISON (2)

Lawrence E. Allen
Anderson
William C. Van Ness II
Summitville

MARION (24)

Richard Brickley
Indianapolis
Warren Coggeshall
Indianapolis
Helen G. Czenkusch
Indianapolis
A. Alan Fisher
Indianapolis
William E. Graham
Indianapolis
Kenneth Gray
Indianapolis
Russell Judd
Indianapolis
E. Henry Lampkin
Indianapolis
George T. Lukemeyer
Indianapolis
Loren M. Martin
Indianapolis
B. T. Maxam
Indianapolis
I. E. Michael
Indianapolis
Robert Mouser
Indianapolis
Paul Muller
Indianapolis
Robert F. Nagan
Indianapolis
Arvin G. Popplewell
Indianapolis
George H. Rawls
Indianapolis
Robert Rudesill
Indianapolis
Charles E. Test
Indianapolis

Alternate Delegates

Walter A. Repay
Munster
Jovencio P. Mangahas
Hammond
Aloys M. Rieser
Crown Point
Robert A. Wolf
Gary
John P. Mirro
Merrillville

John Luce
Michigan City
William G. Moore
La Porte

James L. Mount
Bedford

Ralph E. Reynolds
Middletown
Gerald P. Irwin
Alexandria

Garry L. Bolinger
Indianapolis
Paul Boyce
Indianapolis
James E. Carter
Indianapolis
Fred Dallas
Indianapolis
Charles W. Dill
Indianapolis
Philip N. Eskew, Jr.
Carmel
Ted L. Grisell
Indianapolis
N. Harvey Himelstein
Indianapolis
Richard Hutson
Indianapolis
John Isch
Indianapolis
Karl Koons
Indianapolis
Gerald Kurlander
Indianapolis
Freeman Martin
Indianapolis
Edwin S. McClain
Indianapolis
John Moriarty
Indianapolis
Max Norris
Indianapolis
Robert Parr
Indianapolis
Frederic Rice
Indianapolis
Roland Rust
Indianapolis

1978 House of Delegates

COUNTY AND DELEGATES

Alternate Delegates

MARION

Hugh K. Thatcher, Jr.
Indianapolis
Charles R. Thomas
Indianapolis
Morris E. Thomas
Indianapolis
Douglas E. White, Jr.
Indianapolis
Hugh L. Williams
Indianapolis

Richard Schnute
Indianapolis
Dwight Schuster
Indianapolis
Frank B. Troop
Indianapolis
H. Marshall Trusler
Indianapolis
Edward Wheeler
Indianapolis

MARSHALL (1)

Michael F. Deery
Culver

MIAMI (1)

Lloyd Hill
Peru

Gordon C. Crates
Peru

MONTGOMERY (1)

Carl B. Howland
Crawfordsville

Richard Eggers
Crawfordsville

MORGAN (1)

David A. Eisenberg
Martinsville

NEWTON (1)

Romulo S. Jardenil
Kentland

M. F. Guzman
Morocco

NOBLE (1)

Robert C. Stone
Ligonier

Max E. Sneary
Avilla

ORANGE (1)

Phillip T. Hodgins
Orleans

Charles X. McCalla
Paoli

OWEN-MONROE (3)

Charles W. McClary
Bloomington
Roger F. Robinson
Bloomington
Robert E. Rose
Spencer

Thomas W. Sharp
Bloomington
Richard V. Lee
Bloomington
Rodger L. Buck
Spencer

PARKE-VERMILLION (1)

J. F. Swaim
Rockville

Thomas D. Nicholas
Rockville

PERRY (1)

Robert A. Ward
Tell City

Gene E. Ress
Tell City

PIKE (1)

Donald L. Hall
Petersburg

PORTER (2)

Joel I. Hull
Chesterton
Roy E. Kingma
DeMotte

George A. Azar
Valparaiso
Kenneth A. Black
Valparaiso

POSEY (1)

John Vogel
Mt. Vernon

John Crist
Mt. Vernon

COUNTY AND DELEGATES

Alternate Delegates

PULASKI (1)

Edward L. Hollenberg
Winamac

W. R. Thompson
Winamac

PUTNAM (1)

Fred E. Haggerty
Greencastle

Richard Veach
Bainbridge

RANDOLPH (1)

Lowell W. Painter
Winchester

B. D. Wagoner
Union City

RIPLEY (1)

A. A. Daftary
Batesville

A. E. Jaojoco
Batesville

RUSH (1)

Harry G. McKee
Rushville

ST. JOSEPH (5)

Wallace S. Tirman
South Bend
Alfred C. Cox
South Bend
Richard A. Schaphorst
Mishawaka
Charles O. Hamilton
South Bend
Robert D. Dodd
South Bend

Edward A. Gergesha
South Bend
Michael G. Quinn
South Bend
Samuel Bechtold
South Bend
John O. Hildebrand
South Bend
David Spalding
Mishawaka

SCOTT (1)

Marvin L. McClain
Scottsburg

Jesus C. Bacala
Scottsburg

SHELBY (1)

Wilson L. Dalton
Shelbyville

Floyd Thurston
Shelbyville

SPENCER (1)

Michael O. Monar
Rockport

John C. Glackman
Rockport

STARKE (1)

Herbert C. Ufkes
North Judson

STEUBEN (1)

R. Wyatt Weaver
Angola

Donald G. Mason
Angola

SULLIVAN (1)

Glen McClure
Sullivan

Betty J. Dukes
Dugger

TIPPECANOE (3)

Altamont Bracey
Lafayette
Gilbert Gutwein
Lafayette
George M. Underwood
Lafayette

David Evans
Lafayette
Robert T. Williamson
Lafayette
Robert E. Hannemann
Lafayette

TIPTON (1)

Meredith B. Gossard
Tipton

Raymond Kincaid
Tipton

1978 House of Delegates

COUNTY AND DELEGATES	Alternate Delegates	COUNTY AND DELEGATES	Alternate Delegates
VANDERBURGH (6) Jerry D. Becker Evansville Ray H. Burnikel Evansville Charles W. Hachmeister Evansville Eugene L. Hendershot Evansville Forrest F. Radcliff Evansville L. Ray Stewart Evansville	William H. Getty Evansville John D. Pulcini Evansville Michael J. Dukes Evansville Frank L. Hilton Evansville Elizabeth Sowa Evansville Thomas S. Kandul Evansville	WARRICK (1) Carlos M. Ruiz Boonville	Ernesto M. Camacho Boonville
VIGO (3) Ludimere Lenyo Terre Haute William L. Strecker Terre Haute Paul Humphrey Terre Haute	Robert O. Lancelot Terre Haute J. Lewis Stoelting Terre Haute Robert Reed Terre Haute	WASHINGTON (1) C. Stanley Manship Hardinsburg	Eddie R. Apple Salem
WABASH (1) Fred Poehler La Fountaine		WAYNE-UNION (3) James R. Daggy Richmond Gary W. Snell Liberty	Clarence G. Clarkson Richmond John E. Mader Richmond
		WELLS (1) Donald A. Dian Bluffton	Louis F. Bradley Bluffton
		WHITE (1) Nolan A. Hibner Monticello	Max L. Fields Monticello
		WHITLEY (1) Thomas G. Hamilton Columbia City	C. Jules Heritier Columbia City
		AMSA Gary Lemmon Indianapolis	

Official Call to the House of Delegates

(CONTINUED FROM PAGE 866)

The election of officers will be the first order of business at the final meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1978, and their successors must be elected at the session: Delegates to the American Medical Association to succeed James A. Harshman, Kokomo, Malcolm O. Scamahorn, Pittsboro and Ross L. Egger, Daleville; alternate delegates to succeed George T. Lukemeyer, Indianapolis, Everett E. Bickers, Floyds Knobs and Gilbert M. Wilhelmus, Evansville.

Delegates from the Second, Fifth, Seventh, Eighth and Eleventh districts are reminded that the terms of their trustees will expire October 25, 1978, and new trustees should be elected to succeed the following:

Second—Paul W. Holtzman, Bloomington

Fifth—Cleon M. Schauwecker, Greencastle

Seventh—John G. Pantzer, Indianapolis

Eighth—Jack M. Walker, Muncie

Eleventh—Herbert C. Khalouf, Marion

Some of these elections may already have been held, but they should be reported to the House of Delegates at this session for confirmation.

DONALD F. FOY, Executive Director

1978 House of Delegates

OFFICERS

President—Eli Goodman, Charlestown
President-elect—James A. Harshman, Kokomo
Chairman, Executive Committee—John W. Beeler, Indianapolis
Members, Executive Committee—Joe Dukes, Dugger and
Richard G. Ingram, Montpelier
Chairman of the Board—Martin J. O'Neill, Valparaiso

Treasurer—Arvine G. Popplewell, Indianapolis
Assistant Treasurer—Joseph F. Ferrara, Franklin
Immediate Past President—John W. Beeler, Indianapolis
Speaker—Lloyd L. Hill, Peru
Vice Speaker—Lawrence E. Allen, Anderson
Editor—Frank B. Ramsey, Indianapolis
Executive Director—Donald F. Foy, Indianapolis

SECTION DELEGATES (19)

Allergy—Paul D. Isenberg, Indianapolis
Anesthesiology—Robert E. Longshore, Kokomo
Cutaneous Medicine—
Emergency Medicine—David R. Gettle, Indianapolis
College Health Physicians—
Family Physicians—N. Harvey Himelstein, Indianapolis
Internal Medicine—
Directors of Medical Education—W. Thomas Spain, Evansville
Nervous and Mental Diseases—Philip M. Morton, Indianapolis
Neurological Surgery—

Obstetrics and Gynecology—
Ophthalmology and Otolaryngology—
Orthopedic Surgery—
Pathology and Forensic Medicine—
Pediatrics—Robert Parr, Indianapolis
Public Health and Preventive Medicine—Robert W. Vermilya,
Lafayette
Radiology—William J. Miller, Lafayette
Surgery—Donald M. Schlegel, Indianapolis
Urology—Russell J. Judd, Indianapolis

PAST PRESIDENTS

Herman M. Baker, Evansville
M. C. Topping, Terre Haute
Kenneth L. Olson, South Bend
Earl W. Mericle, Indianapolis
Guy A. Owsley, Hartford City
Maurice E. Glock, Fort Wayne
Donald E. Wood, Indianapolis
Joseph M. Black, Seymour
Eugene S. Rifner, Van Buren

Patrick J. V. Corcoran, Evansville
Lowell H. Steen, Evansville
Malcolm O. Scamahorn, Pittsboro
Peter R. Petrich, Attica
James H. Gosman, Indianapolis
Joe Dukes, Dugger
Gilbert M. Wilhelmus, Evansville
Vincent J. Santare, Munster
John W. Beeler, Indianapolis

TRUSTEES

1st District—John A. Bizal, Evansville
2nd District—Paul W. Holtzman, Bloomington
3rd District—Thomas A. Neathamer, Jeffersonville
4th District—Howard C. Jackson, Madison
5th District—Cleon M. Schauwecker, Greencastle
6th District—Davis W. Ellis, Rushville
7th District—Donald C. Mc Callum, Indianapolis
—John G. Pantzer, Indianapolis
8th District—Jack M. Walker, Muncie
9th District—John A. Knote, Lafayette
10th District—Martin J. O'Neill, Valparaiso
11th District—Herbert C. Khalouf, Marion
12th District—Alvin J. Haley, Fort Wayne
13th District—Donald S. Chamberlain, South Bend

ALTERNATE TRUSTEES

1st District—De Verre Gourieux, Evansville
2nd District—Edgar R. Cantwell, Vincennes
3rd District—Richard G. Huber, Bedford
4th District—Mark M. Bevers, Seymour
5th District—William G. Bannon, Terre Haute
6th District—Dan W. Hibner, Richmond
7th District—I. E. Michael, Indianapolis
—Gerald J. Kurlander, Indianapolis
8th District—Ted S. Doles, Middletown
9th District—Max N. Hoffman, Covington
10th District—Leonard W. Neal, Munster
11th District—Frederick C. Poehler, La Fontaine
12th District—Franklin A. Bryan, Fort Wayne
13th District—John W. Luce, Michigan City

AMA DELEGATES

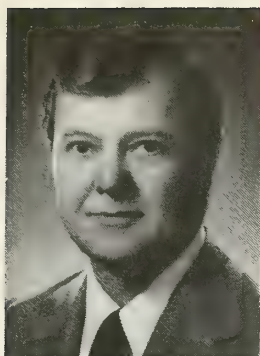
Patrick J. V. Corcoran, Evansville
Peter R. Petrich, Attica
James A. Harshman, Kokomo
Malcolm O. Scamahorn, Pittsboro
Ross L. Egger, Daleville

AMA ALTERNATE DELEGATES

Thomas C. Tyrrell, Hammond
Marvin E. Priddy, Fort Wayne
George T. Lukemeyer, Indianapolis
Gilbert M. Wilhelmus, Evansville
Everett E. Bickers, Floyds Knobs



ELI GOODMAN, M.D.
President
Indiana State Medical Association
1977-1978



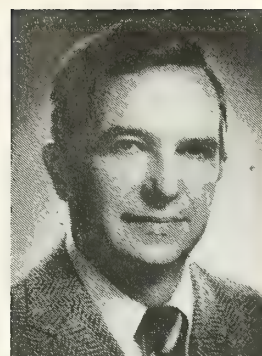
MARTIN J. O'NEILL, M.D.
Chairman of Board
Valparaiso



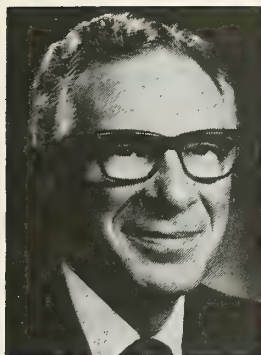
**JAMES A. HARSHMAN,
M.D.**
President-Elect
Kokomo



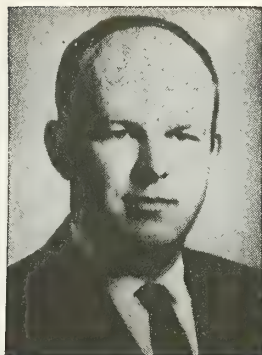
**ARVINE POPPLEWELL,
M.D.**
Treasurer
Indianapolis



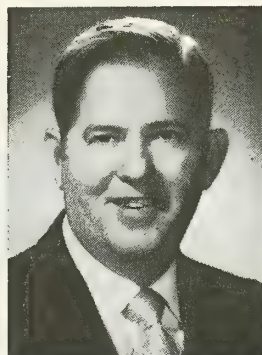
JOHN W. BEELER, M.D.
Chairman
Executive Committee
Indianapolis



JOSEPH F. FERRARA, M.D.
Assistant Treasurer
Franklin



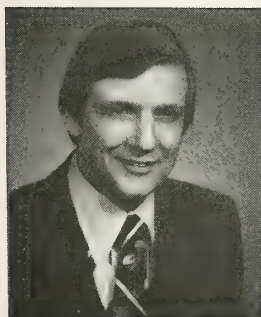
RICHARD INGRAM, M.D.
Executive Committee
Montpelier



JOE DUKES, M.D.
Executive Committee
Dugger



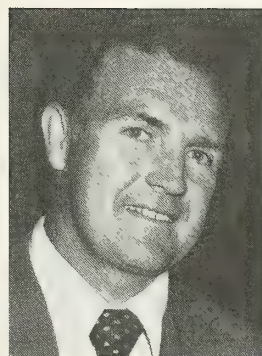
LLOYD L. HILL, M.D.
Speaker of the House
Peru



**LAWRENCE E. ALLEN,
M.D.**
Vice-Speaker
Anderson



MRS. RUTH GATTMAN
President, Auxiliary
Elkhart



DONALD F. FOY
Executive Director
Indianapolis



KENNETH W. BUSH
Assistant Executive
Director
Indianapolis

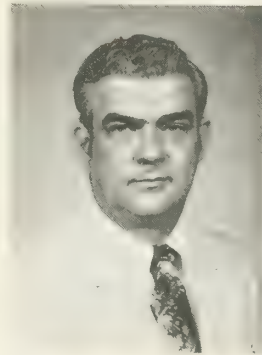
Board of Trustees



JOHN BIZAL, M.D.
First District
Evansville



PAUL W. HOLTZMAN, M.D.
Second District
Bloomington



THOMAS NEATHAMER, M.D.
Third District
Jeffersonville



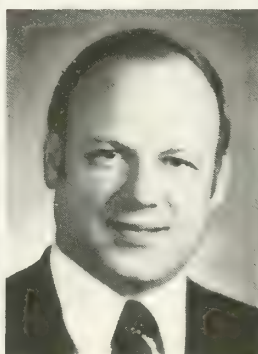
HOWARD C. JACKSON, M.D.
Fourth District
Madison



CLEON W. SCHAUWECKER, M.D.
Fifth District
Greencastle



DAVIS W. ELLIS, M.D.
Sixth District
Rushville



DONALD McCALLUM, M.D.
Seventh District
Indianapolis



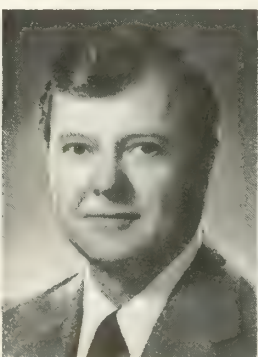
JOHN G. PANTZER, M.D.
Seventh District
Indianapolis



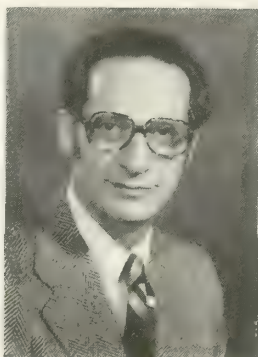
JACK M. WALKER, M.D.
Eighth District
Muncie



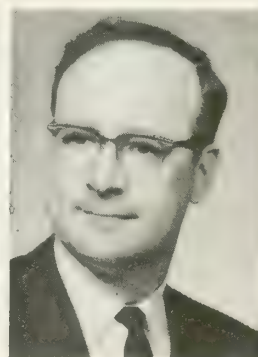
JOHN A. KNOTE, M.D.
Ninth District
Lafayette



MARTIN J. O'NEILL, M.D.
Tenth District
(Chairman of Board)
Valparaiso



HERBERT C. KHALOUF, M.D.
Eleventh District
Marion

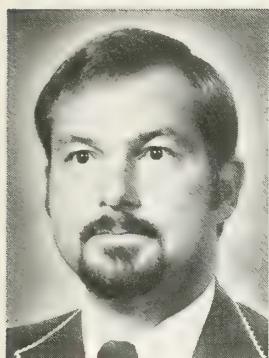


ALVIN J. HALEY, M.D.
Twelfth District
Fort Wayne

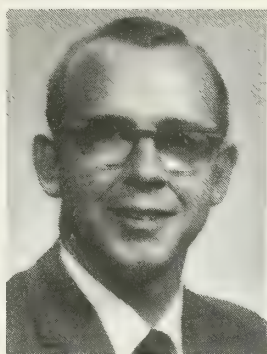


DONALD S. CHAMBERLAIN, M.D.
Thirteenth District
South Bend

Alternate Trustees



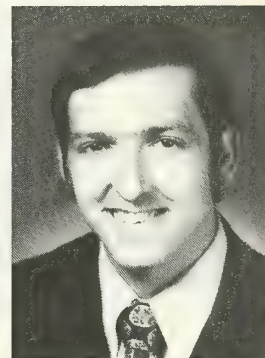
E. DeVERRE GOURIEUX, M.D.
First District
Evansville



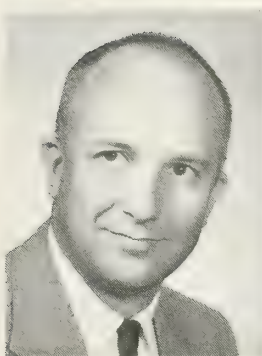
EDGAR R. CANTWELL, M.D.
Second District
Vincennes



RICHARD G. HUBER, M.D.
Third District
Bedford



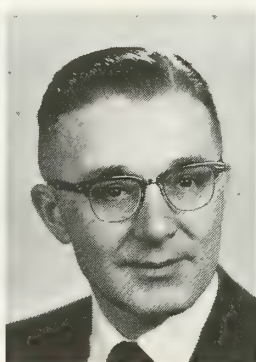
MARK M. BEVERS, M.D.
Fourth District
Seymour



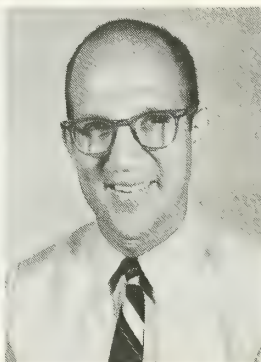
WILLIAM G. BANNON, M.D.
Fifth District
Terre Haute



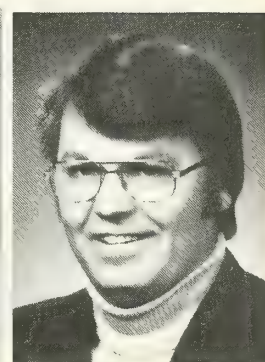
DAN W. HIBNER, M.D.
Sixth District
Richmond



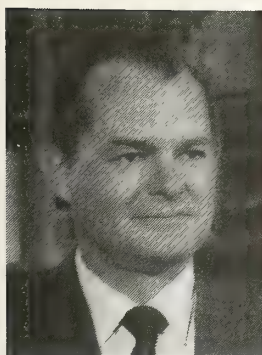
I. E. MICHAEL, M.D.
Seventh District
Indianapolis



GERALD J. KURLANDER, M.D.
Seventh District
Indianapolis



TED S. DOELS, M.D.
Eighth District
Middletown



MAX N. HOFFMAN, M.D.
Ninth District
Covington



LEONARD W. NEAL, M.D.
Tenth District
Munster



FRED C. POEHLER, M.D.
Eleventh District
La Fontaine



FRANKLIN A. BRYAN, M.D.
Twelfth District
Fort Wayne



JOHN W. LUCE, M.D.
Thirteenth District
Michigan City

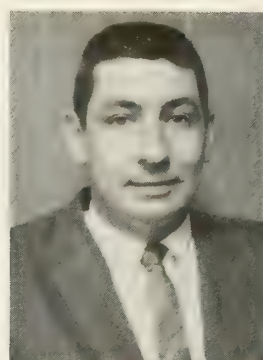
Delegates to the AMA



**JAMES A. HARSHMAN,
M.D.**
Kokomo



**MALCOLM O.
SCAMAHORN, M.D.**
Pittsboro



ROSS L. EGGER, M.D.
Daleville



**PATRICK J. V. CORCORAN,
M.D.**
Evansville



PETER R. PETRICH, M.D.
Attica

Alternate Delegates to the AMA



**GEORGE T. LUKEMEYER,
M.D.**
Indianapolis



**EVERETT E. BICKERS,
M.D.**
Floyds Knobs



**GILBERT M. WILHELMUS,
M.D.**
Evansville

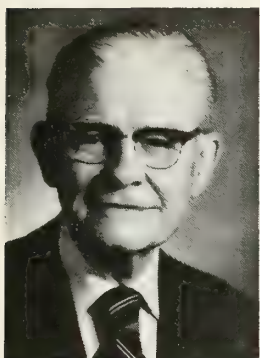


**THOMAS C. TYRRELL,
M.D.**
Hammond



MARVIN E. PRIDDY, M.D.
Fort Wayne

Medical Staff—The Journal



FRANK B. RAMSEY, M.D.
Editor
Indianapolis



A. W. CAVINS, M.D.
Consulting Editor
Terre Haute



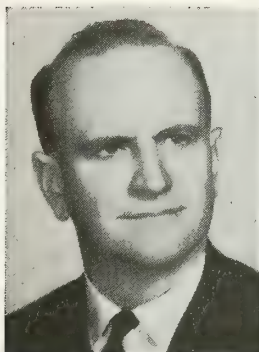
L. G. MONTGOMERY, M.D.
Consulting Editor
Muncie



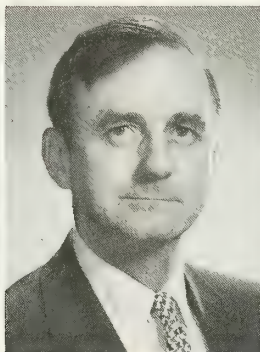
SAMUEL R. MERCER, M.D.
Consulting Editor
Fort Wayne



IRVIN W. WILKENS, M.D.
Consulting Editor
Indianapolis



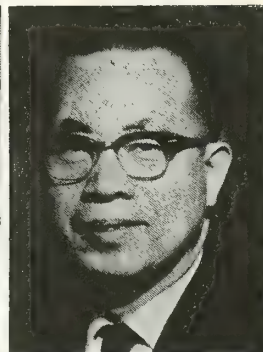
W. D. SNIVELY, JR., M.D.
Consulting Editor
Evansville



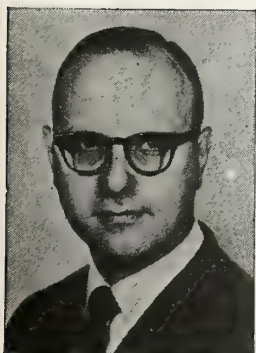
CHARLES A. BONSETT, M.D.
Consulting Editor
Indianapolis



ALVIN J. HALEY, M.D.
Editorial Board
Fort Wayne



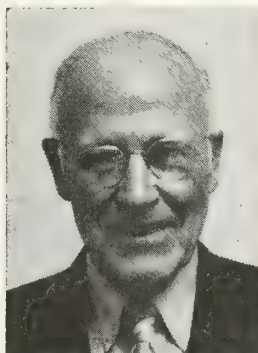
WEI-PING LOH, M.D.
Editorial Board
Gary



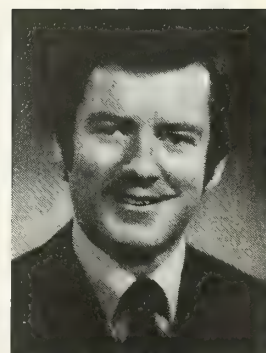
STEVEN C. BEERING, M.D.
Editorial Board
Indianapolis



ELTON HEATON, M.D.
Editorial Board
Madison



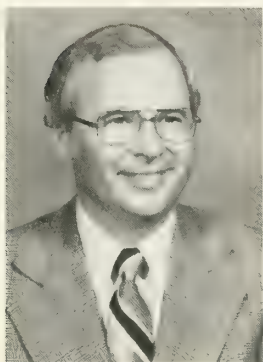
PAUL S. RHOADS, M.D.
Editorial Board
Richmond



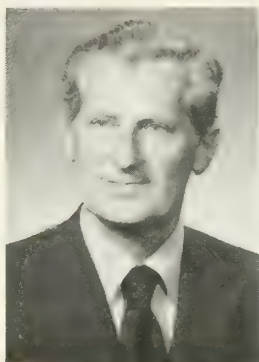
RODNEY A. MANNION, M.D.
Editorial Board
LaPorte

Section Officers

Radiology

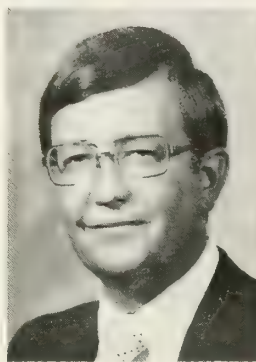


WILLIAM MILLER, M.D.
Chairman
Lafayette



WALLACE TIRMAN, M.D.
Secretary
South Bend

Pediatrics

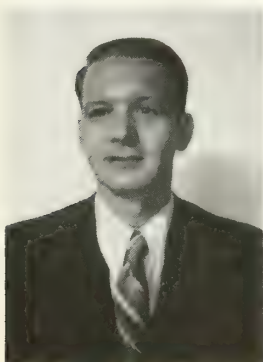


**ROBERT HANNEMANN,
M.D.**
Chairman
Lafayette

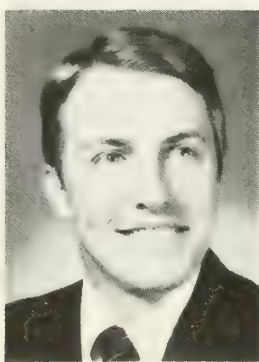


**WILLIAM C. ASHMAN,
M.D.**
Secretary
Fort Wayne

Nervous and Mental Diseases



PHILIP M. MORTON, M.D.
Chairman
Indianapolis

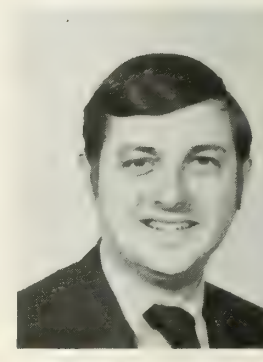


**JEFFREY J. KELLAMS,
M.D.**
Secretary
Indianapolis

Cutaneous Medicine



EDWARD L. PROBST, M.D.
Chairman
Columbus



PATRICK LOGAN, M.D.
Secretary
Indianapolis

Pathology and Forensic Medicine



GEORGE BRANAM, M.D.
Chairman
Muncie

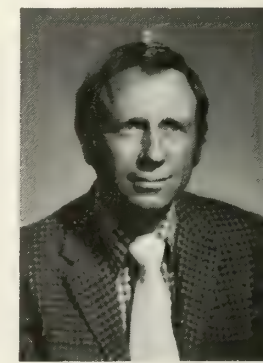


EMMETT C. PIERCE, M.D.
Secretary
Greenfield

Directors of Medical Education



W. THOMAS SPAIN, M.D.
Chairman
Evansville



**ROBERT D. ROBINSON,
JR., M.D.**
Secretary
Indianapolis

Section Officers

Surgery

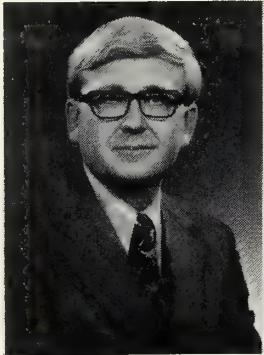


GLEN McCLURE, M.D.
Chairman
Sullivan



JAMES A. MADURA, M.D.
Secretary
Indianapolis

Anesthesiology

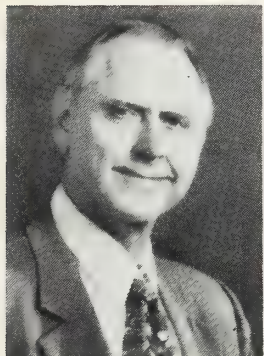


ROBERT K. STOELTING, M.D.
Chairman
Carmel

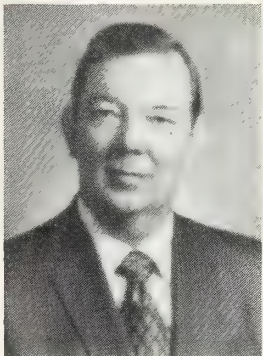


DEAN L. STRYCKER, M.D.
Secretary
Niles, Mich.

Internal Medicine



CHARLES W. MAGNUSON, M.D.
Chairman
South Bend

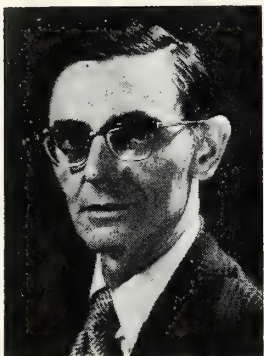


R. B. SCHNUTE, M.D.
Secretary
Indianapolis

Public Health & Preventive Medicine

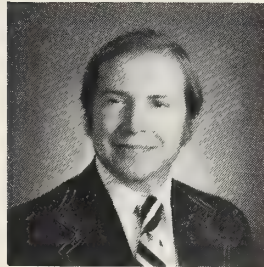


ROBERT K. McKECHNIE, M.D.
Chairman
Jeffersonville



DAVID EDWARDS, M.D.
Secretary
Indianapolis

Ophthalmology and Otolaryngology

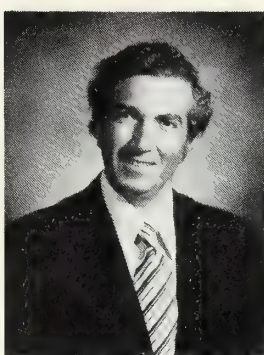


JOHN BIZAL, M.D.
Chairman
Evansville

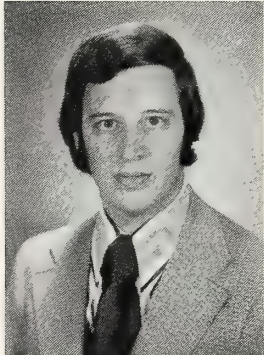


DANIEL R. EVANS, M.D.
Secretary
Valparaiso

Family Physicians



HARVEY HIMELSTEIN, M.D.
Chairman
Indianapolis



BERNARD J. EMKES, M.D.
Secretary
Indianapolis

Section Officers

Allergy



PAUL D. ISENBERG, M.D.
Chairman
Indianapolis



BEAUFORT A. SPENCER, M.D.
Secretary
Bloomington

Emergency Medicine

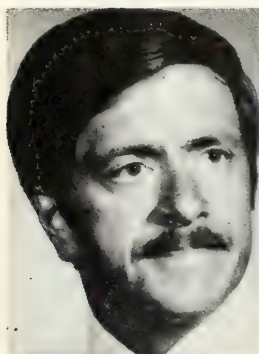


DAVID R. GETTLE, M.D.
Chairman
Noblesville



CAROLYN CUNNINGHAM, M.D.
Secretary
Indianapolis

Urology

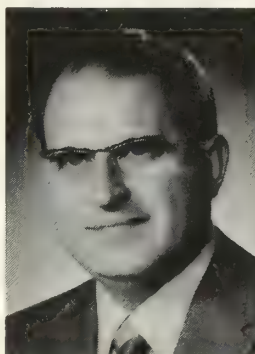


RUSSELL L. JUDD, M.D.
Chairman
Indianapolis



DAVID SCHLUETER, M.D.
Secretary
Fort Wayne

Neurological Surgery



LOUIS W. CONWAY, M.D.
Chairman
Lafayette



DANIEL F. COOPER, M.D.
Secretary
Indianapolis

Orthopedic Surgery



FRANK THROOP, M.D.
Chairman
Indianapolis



GEORGE RAPP, M.D.
Secretary
Indianapolis

Schedule of Events—129th Annual Convention

Marriott Inn and Kentuckiana Convention and Sports Center Clarksville

(All events will be on Eastern Daylight Time, one hour ahead of Indianapolis)

The scientific program for the 129th Annual Convention of the Indiana State Medical Association is acceptable for four prescribed hours by the American Academy of Family Physicians. The prescribed hours are for attendance at the Family Physicians Section meeting.

(Scientific programs presented at the 1978 ISMA Convention are accredited on an hour-for-hour basis for inclusion in Category I of the application for the AMA Physician's Recognition Award. Hours allowable in any given program are shown below the program listing.)

SATURDAY, OCTOBER 21—Schedule of Events

7 p.m.

Board of Trustees Annual Formal Dinner
Merry Wives of Windsor

Reception
Palm Terrace (Poolside)

SUNDAY, OCTOBER 22—Schedule of Events

- 9 a.m.** **Registration**
Main Lobby, Marriott Inn
- 9 a.m.** **AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, INC.,
INDIANA CHAPTER**
Shakespeare No. 3
Immunology
L.Y. Frank Wu, M.D., Indianapolis
9-10:15 a.m.
Break
10:15 a.m.
Allergies
L.Y. Frank Wu, M.D., Indianapolis
10:30-11:45 a.m.
Buffet Luncheon
Palm Terrace (Poolside)
11:45 a.m.
Public Awareness Against Rape
Coordinator, Connie Guthrie, Jeffersonville
1-3:30 p.m.
- 9 a.m.-4 p.m.** **PRACTICE MANAGEMENT PROGRAM**
Presented by Clayton L. Scroggins Association, Cincinnati, Ohio
Shakespeare No. 1
- 9 a.m.** **Executive Committee Meeting**
I-302, Marriott Inn
- 11:30 a.m.** **Board of Trustees Meeting (Luncheon)**
Merry Wives of Windsor
- Noon** **Editorial Board Meeting (Luncheon)**
Julius Caesar Room
- 10 a.m.** **ISMA SECTION ON RADIOLOGY AND INDIANA ROENT-
GEN SOCIETY**
(Possible Hours of Accreditation: 1.0)
Shakespeare No. 2
Executive Committee Meeting, Indiana Roentgen Society
10 a.m.
Section Meeting
Election of 1979 Section Officers
11 a.m.
Buffet Luncheon
Palm Terrace (Poolside)
Microwave Radiation in Treatment of Neoplasia
Ned B. Hornback, M.D., Indianapolis
1-2 p.m.
- 11 a.m.** **ISMA SECTION ON SURGERY, INDIANA CHAPTER, AMER-
ICAN COLLEGE OF SURGERY AND INDIANA CHAPTER,
INTERNATIONAL COLLEGE OF SURGEONS**
(Possible Hours of Accreditation: 2.0)
Shakespeare No. 4

SUNDAY, OCTOBER 22—Schedule of Events

Replantation

Harold E. Kleinert, M.D., Louisville, Ky.
11 a.m.

Buffet Luncheon

Palm Terrace (Poolside)

Other Applications of Microsurgery Including Free Tissue Transfer

Graham D. Lister, F.R.C.S., Louisville, Ky.
1-2 p.m.

Election of 1979 Section Officers

11 a.m.

ISMA SECTION ON NEUROLOGICAL SURGERY

(Possible Hours of Accreditation: 3.0)

Program to be Announced

11 a.m.-3 p.m.

Buffet Luncheon

Palm Terrace (Poolside)

Election of 1979 Section Officers

Noon

ISMA SECTION ON ALLERGY

(Possible Hours of Accreditation: 2.0)

I-302, Marriott Inn

Extrinsic Asthma

Round table discussion by Paul D. Isenberg, M.D., Indianapolis and L.Y. Frank Wu, M.D., Indianapolis
Noon-2 p.m.

Election of 1979 Section Officers

Noon

ISMA SECTION ON DIRECTORS OF MEDICAL EDUCATION AND ASSOCIATION OF INDIANA DIRECTORS OF MEDICAL EDUCATION

(Possible Hours of Accreditation: 1.5)

Cleopatra Room

Buffet Luncheon

Palm Terrace (Poolside)

Noon

Primary Care—Its Promise and Future

E. Harvey Estes, M.D., Durham, N.C.
1 p.m.

Discussion

2 p.m.

Annual Business Meeting and Election of 1979 Section Officers

2:30 p.m.

3-5 p.m.

HOUSE OF DELEGATES MEETING

Ballroom

7 p.m.

REFERENCE COMMITTEE MEETINGS

Ref. Committee No. 1—*Antony*

Ref. Committee No. 2—*Shakespeare No. 2*

Ref. Committee No. 3—*Shakespeare No. 3*

Ref. Committee No. 4—*Shakespeare No. 4*

Ref. Committee No. 5—*Merry Wives of Windsor*

Special Reference Committee on AMA-ISMA Relations—*Shakespeare No. 1*

MONDAY, OCTOBER 23—Schedule of Events

- 7:30 a.m.** **Board of Trustees Breakfast**
Merry Wives of Windsor
- 7:30 a.m.** **INDIANA POLITICAL ACTION COMMITTEE (Breakfast)**
Speaker to be Announced
Ballroom
- 9 a.m.** **Registration**
Main Lobby, Marriott Inn
- 10 a.m.** **Golf Tournament**
Jeffersonville Elks Club
- Tennis Tournament**
Time and Location to be Announced
- 11:30 a.m.** **Buffet Luncheon**
Palm Terrace (Poolside)
- 11:30 a.m.** **ASSOCIATION OF AMERICAN PHYSICIANS AND SUR-
GEONS (Luncheon)**
Shakespeare No. 2

Prognosis of Private Practice: What It Takes to Stay Alive
Albert G. J. Cullum, M.D., Middlesboro, Ky.
- 1 p.m.** **GENERAL SCIENTIFIC MEETING**
(Possible Hours of Accreditation: 2.0)
**George Rogers Clark Room, Kentuckiana Convention and
Sports Center**

Thomas A. Neathamer, M.D., Chairman, Commission on Convention Arrange-
ments, Presiding

Welcome—Eli Goodman, M.D., President, Indiana State Medical Association
1 p.m.

Questions Your Patients Ask About Nutrition
Philip L. White, Sc.D., Chicago
1 p.m.

**History, Indications, Contraindications, Method and Side Effects of Intravenous
Hyperalimentation**
Robert W. Luther, M.D., Memphis, Tenn.
(Courtesy of USV Pharmaceuticals Corporation)
2 p.m.

Opening of Technical and Scientific Exhibits
Kentuckiana Convention and Sports Center
2 p.m.

MONDAY, OCTOBER 23—Schedule of Events

- 3 p.m.**
- IMPAIRED PHYSICIAN COMMITTEE PROGRAM**
(Possible Hours of Accreditation: 2.0)
George Rogers Clark Room, Kentuckiana Convention and Sports Center
- Gerald P. Johnston, M.D., Chairman, ISMA Impaired Physician Committee, Presiding
- The Alcoholic Physician**
LeClair Bissell, M.D., New York, N.Y.
3:10 p.m.
- The Drug-Dependent Physician**
E. Richard Dorsey, M.D., Cincinnati, Ohio
3:40 p.m.
- The Physician with Major Neuropsychiatric Disorders**
Hugh C. Hendrie, M.B. Ch.B., Indianapolis
4:10 p.m.
- Questions and Discussion**
4:40 p.m.
- 3-5 p.m.**
- MEET THE PROFESSOR**
(Possible Hours of Accreditation for Entire Session: 2.0)
Indiana University School of Medicine has arranged to conduct these conferences.
John F. Phillips, M.D., Chairman
- Behavioral Pediatrics and the Primary Care Physician**
Morris Green, M.D., Indianapolis
Shakespeare No. 2
- Cerebrovascular Disease: A Birdseye View**
Mark L. Dyken, M.D., Indianapolis
Shakespeare No. 3
- Managing the Complications of Acute Myocardial Infarction**
R. Joe Noble, M.D., Indianapolis
Shakespeare No. 4
- Pediatric Otolaryngology**
Mark I. Singer, M.D., Indianapolis
Merry Wives of Windsor
- 7:30-10:30 p.m.**
- CRUISE ON THE BELLE OF LOUISVILLE—on the Ohio River**
Buffet Dinner, Dancing, Dixieland Band

TUESDAY, OCTOBER 24—Schedule of Events

7:30 a.m.

Board of Trustees Breakfast

George Rogers Clark Room, Kentuckiana Convention and Sports Center

8:30 a.m.

Opening of Technical and Scientific Exhibits

Kentuckiana Convention and Sports Center

Registration Continues

Kentuckiana Convention and Sports Center

8:15 a.m.

ISMA SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH AND INDIANA ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

(Possible Hours of Accreditation: 3.0)

I-302, Marriott Inn

Robert K. McKechnie, M.D., Jeffersonville, Ind., President, Indiana Association of Health Physicians, Presiding

Scoliosis

G. Paul DeRosa, M.D., Indianapolis

8:15 a.m.

Discussion

9:15 a.m.

Break

10 a.m.

Reyes Syndrome

John C. Partin, M.D., Cincinnati, Ohio

10:15 a.m.

Election of 1979 Section Officers

8:30 a.m.-4:20 p.m. ISMA SECTION ON INTERNAL MEDICINE, AMERICAN COLLEGE OF PHYSICIANS, INDIANA REGIONAL MEETING IN ASSOCIATION WITH INDIANA SOCIETY OF INTERNAL MEDICINE

(Possible Hours of Accreditation: 6.0)

Shakespeare No. 3

Registration

8:15 a.m.

Welcome—George T. Lukemeyer, M.D., F.A.C.P., ACP Governor for Indiana

8:45 a.m.

Is Aspirin a Major Breakthrough in the Treatment of Stroke?

Mark L. Dyken, M.D., F.A.C.P., Indianapolis

9 a.m.

Uses and Abuses of Psychotropic Drugs

Hugh C. Hendrie, M.B. Ch.B., Indianapolis

9:30 a.m.

Break

10 a.m.

Current Concepts in the Management of Obesity

Philip L. White, Sc.D., Chicago

10:20 a.m.

TUESDAY, OCTOBER 24—Schedule of Events

Today's Look at Tomorrow's Electrocardiograms

Leo G. Horan, M.D., F.A.C.P., Louisville, Ky.
10:50 a.m.

Report on American College of Physicians' Affairs

George W. Pedigo, Jr., M.D., F.A.C.P., Regent, American College of Physicians, Louisville, Ky.
11:20 a.m.

Luncheon, Shakespeare No. 4

11:50 a.m.

Public Involvement—A Practice Responsibility

E. Henry Lamkin, Jr., M.D., F.A.C.P., Luncheon Speaker

Call to Order—Charles W. Magnuson, Sr., M.D., F.A.C.P., President, Indiana Society of Internal Medicine

1:20 p.m.

Current Activities of the American Society of Internal Medicine

William A. Millhon, M.D., F.A.C.P., Trustee, American Society of Internal Medicine, Columbus, Ohio
1:30 p.m.

Tips on Interpreting Chest X-Rays

Vernon A. Vix, M.D., Indianapolis
2 p.m.

Gastrointestinal Manifestations of Diabetes Mellitus

Frank Vinicor, M.D., Associate Director, Diabetes Research and Training Center, I.U. School of Medicine
2:30 p.m.

Break

3 p.m.

Adjuvant Chemotherapy in Breast Carcinoma

William B. Fisher, M.D., Muncie, Ind.
3:20 p.m.

Current Therapy in Metastatic Breast Carcinoma

Richard B. Schnute, M.D., Indianapolis
3:50 p.m.

Adjournment

4:20 p.m.

10 a.m.

ISMA SECTION ON PEDIATRICS AND INDIANA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

(Possible Hours of Accreditation: 6.0)

K-202, Marriott Inn

Asthma

Charles F. Kemper, M.D., Jeffersonville, Ind.
10 a.m.

Neonatal Intensive Care in Community Hospitals

Jack A. Cheek, Jr., M.D., Evansville, Ind.
11 a.m.

Lunch

Kentuckiana Convention and Sports Center
Noon

TUESDAY, OCTOBER 24—Schedule of Events

Genetics and Genetic Counseling

Nuhad D. Dinno, M.D., Louisville, Ky.

1 p.m.

Chronic Diarrhea in Infants and Children

Joseph F. Fitzgerald, M.D., Indianapolis

2 p.m.

Hyperactivity in Children

Jeff Alexander, M.D. Indianapolis

3 p.m.

Update on Infant Nutritional Requirements and Feeding Recommendations

Robert E. Hannemann, M.D., Lafayette, Ind.

4 p.m.

Election of 1979 Section Officers

10 a.m.-4 p.m.

ISMA SECTION ON EMERGENCY PHYSICIANS AND INDIANA CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

(Possible Hours of Accreditation: 4.5)

Viewing Room, Kentuckiana Convention and Sports Center

Cost Effectiveness and Emergency Medicine

Panel: An Emergency Physician, A Hospital Representative, and a Blue Cross-Blue Shield Representative

10-11:30 a.m.

Election of 1979 Section Officers

Lunch

Kentuckiana Convention and Sports Center

11:30 a.m.

Basic CPR Course

Open to all ISMA members

1-4 p.m.

10 a.m.-3 p.m.

ISMA SECTION ON FAMILY PRACTICE AND INDIANA ACADEMY OF FAMILY PHYSICIANS

(Possible Hours of Accreditation: 3.5)

George Rogers Clark Room, Kentuckiana Convention and Sports Center

Hormone Receptor Assay for Breast Carcinoma

Wei-Ping Loh, M.D., Gary, Ind.

10 a.m.

Fecal Occult Blood Testing and Colonoscopy

Lee G. Jordan, M.D., Indianapolis

10:45 a.m.

Lunch, Kentuckiana Convention and Sports Center

11:30 a.m.

Diagnostic Imaging—Breast, Lung and Colon Cancer

Eugene D. Van Hove, M.D., Indianapolis

1 p.m.

A Community Cancer Program

William M. Dugan, Jr., M.D., Indianapolis

2 p.m.

Election of 1979 Section Officers

TUESDAY, OCTOBER 24—Schedule of Events

Noon

ISMA SECTION ON UROLOGY AND INDIANA UROLOGICAL ASSOCIATION

(Possible Hours of Accreditation: 3.0)

Ballroom, Marriott Inn

Lunch

Kentuckiana Convention and Sports Center

Noon

Prosthetics in Urology

William L. Furlow, M.D., Rochester, Minn.

1 p.m.

Pitfalls and Future of Prosthetic Surgery for Impotence and Incontinence

Discussion: William Furlow, M.D., Rochester, Minn.

John Mulcahy, M.D., Indianapolis

Arnold Melman, M.D., Indianapolis

2 p.m.

Pyelogram Conference

3 p.m.

Election of 1979 Section Officers

11:30 a.m.

Past Presidents' Luncheon

Mint Julep Garden

1 p.m.

Small County Delegates Meeting

Shakespeare No. 3

2:30 p.m.

MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES

I-302, Marriott Inn

Diagnosis and Treatment of Psychiatric Problems in the Elderly

Dwight W. Schuster, M.D., Indianapolis

2:30 p.m.

6 p.m.

Reception for Fifty-Year Club

Merry Wives of Windsor

6:30 p.m.

President's Reception

Palm Terrace (Poolside)

7:30 p.m.

President's Dinner

Ballroom

WEDNESDAY, OCTOBER 25—Schedule of Events

7:30 a.m.

Board of Trustees Breakfast

George Rogers Clark Room, Kentuckiana Convention and Sports Center

8:30 a.m.-Noon

Opening of Technical and Scientific Exhibits

Kentuckiana Convention and Sports Center

9 a.m.

Final Meeting of the House of Delegates

Ballroom, Marriott Inn

Fifty-Year Club—1978

ALLEN COUNTY

Samuel R. Mercer, Ft. Wayne

CLARK COUNTY

John S. Huoni, Jeffersonville

DELAWARE-BLACKFORD COUNTY

Guy A. Owsley, Hartford City

ELKHART COUNTY

Milo O. Lundt, Elkhart

Ralph H. Young, Goshen

GREENE COUNTY

Mathias S. Mount, Bloomfield

HOWARD COUNTY

Richard P. Good, Kokomo

HUNTINGTON COUNTY

Harold S. Brubaker, Sun City Center, Fla.

Robert D. Meiser, Panama City Beach, Fla.

LAKE COUNTY

Frank J. Kendrick, Goshen

McKinley Voorhies, Gary

John M. Zivich, E. Chicago

MADISON COUNTY

Milton J. Daus, Anderson

MARION COUNTY

John T. Emhardt, Indianapolis

Joseph O. Flora, Indianapolis

Young Dai I. Kim, Seattle, Wash.

Isadore J. Kwitny, Indianapolis

Russel C. Rees, Indianapolis

Joe W. Sovine, Indianapolis

MIAMI COUNTY

Donald W. Ferrara, Peru

MONTGOMERY COUNTY

Wemple Dodds, Crawfordsville

NOBLE COUNTY

August L. Fipp, Ft. Wayne

PARKE-VERMILLION COUNTY

Gerald F. Kempf, Spring Valley, Ohio

PORTER COUNTY

Jack H. Oster, Valparaiso

PUTNAM COUNTY

Earle V. Wiseman, Greencastle

ST. JOSEPH COUNTY

Frederick W. Buechner, South Bend

Paul E. Haley, South Bend

Marion W. Hillman, Sarasota, Fla.

Eli Rubens, Sarasota, Fla.

Robert B. Sanderson, South Bend

TIPPECANOE COUNTY

Frank W. Ratcliff, Lafayette

VIGO COUNTY

Leander A. Malone, Terre Haute

Floyd C. Riggs, Terre Haute

Malachi C. Topping, Marco, Fla.

WABASH COUNTY

Ladoska Z. Bunker, No. Manchester

William E. Pearson, Wabash

WAYNE-UNION COUNTY

Paul W. Blossom, Richmond

Morris D. Wertenberger, Richmond

Convention Arrangements Commission—1978

COMMISSION ON CONVENTION ARRANGEMENTS: Thomas A. Neathamer, Jeffersonville, chairman; Stanley M. Chernish, Indianapolis, vice-chairman; Eugene Austin, Evansville; James N. Topoligus, Bloomington; Richard McIlroy, Columbus; Fred Haggerty, Greencastle; James Johnson, Richmond; Thomas W. Alley, Indianapolis; Clarence Asburn, Muncie; Max Hoffman, Covington; Daniel T. Ramker, Hammond; Shirley T. Khalouf, Marion; Thomas A. Felger, Fort Wayne; Glen McClure, Sullivan; Fred Adler, Munster; Victor H. Muller, Indianapolis; Mrs. James Koontz, Vincennes, Auxiliary Liaison.

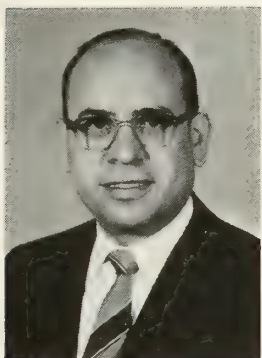
GOLF TOURNAMENT: Clemente F. Oca, Jeffersonville, chairman.

TENNIS TOURNAMENT: Gordon L. Gutmann, Jeffersonville, chairman.

SCIENTIFIC EXHIBITS: George T. Lukemeyer, Indianapolis, chairman.

AUXILIARY AND WOMEN'S ACTIVITIES: Mrs. Everett E. Bickers, Floyds Knobs, chairman; Mrs. Joseph Mudd, Clarksville, co-chairman; Mrs. Joseph Bruckman, New Albany, treasurer.

Guest Speakers



MORRIS GREEN, M.D.

Indianapolis

Perry W. Lesh Professor and Chairman, Department of Pediatrics, I.U. School of Medicine; physician-in-chief, James Whitcomb Riley Hospital for Children; specialty in pediatrics; M.D. degree from Indiana University.



MARK I. DYKEN, M.D.

Indianapolis

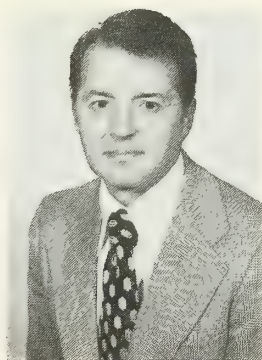
Professor and Chairman, Department of Neurology, I.U. Medical School; principal investigator and director, I.U.M.C. Cerebral Vascular Clinical Research Center; Fellow, Council on Cerebral Vascular Disease, American Heart Association; chairman, I.U. Medical School Committee on Brain Survival; M.D. degree from Indiana University.



WILLIAM L. FURLOW, M.D.

Rochester, Minn.

Consultant, Department of Urology, Mayo Clinic; Associate Professor of Urology, Mayo Medical School; Chairman, Urodynamic Devices Committee, International Urodynamics Society; member, International Society of Urologists, International Urodynamic Society, American College of Surgeons, American College of General Practitioners; M.D. degree from George Washington University.



VERNON A. VIX, M.D.

Indianapolis

Professor of Radiology and Director of Diagnosis, I.U. School of Medicine; Certified, American Board of Internal Medicine, American Board of Radiology; M.D. degree from University of Pennsylvania.



LEO G. HORAN, M.D.

Louisville, Ky.

Professor and Chairman, Department of Medicine, University of Louisville School of Medicine; Chief, Medical Service, Louisville General Hospital; Fellow, American College of Physicians, American College of Chest Physicians, American College of Cardiology, and Council on Clinical Cardiology of American Heart Association; M.D. degree from Tulane University.



DWIGHT W. SCHUSTER, M.D.

Indianapolis

Private practice in neuro-psychiatry; certified by American Board of Psychiatry and Neurology; Fellow, American Psychiatric Association, and American College of Physicians; Associate Professor of Clinical Psychiatry, I.U. School of Medicine; M.D. degree from Indiana University.



HUGH CURTIS HENDRIE, M.B. Ch.B.

Indianapolis

Professor and Chairman, Department of Psychiatry, and Executive Director, Institute of Psychiatric Research, I. U. Medical School; Albert Eugene Sterne Professor of Clinical Psychiatry, I.U.; Fellow, International Association of Social Psychiatry, Royal College of Physicians of Canada; founding member, Royal College of Psychiatrists; M.B. Ch.B. degree from University of Glasgow, Scotland.



E. HENRY LAMKIN, JR., M.D.

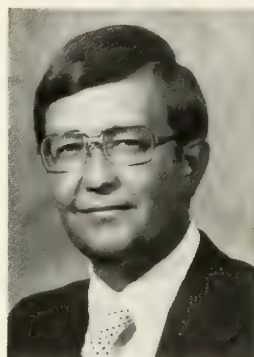
Indianapolis

Private practice, internal medicine; sub-specialty in endocrinology, metabolism and rheumatology; teaching staff, Methodist Hospital, Indianapolis; Assistant Clinical Professor, I.U. School of Medicine; certified, American Board of Internal Medicine; Fellow, American College of Physicians; State Representative from Marion County; Majority Leader, House of Representatives; M.D. degree from Indiana University.

Guest Speakers



R. JOE NOBLE, M.D.
Indianapolis
Clinical Associate Professor, Department of Medicine, I.U. Hospital; specialty, cardiology; M.D. degree from Indiana University.



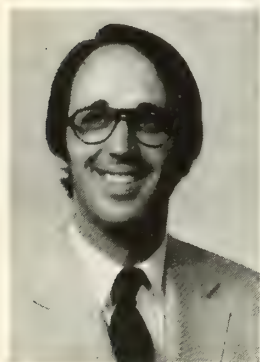
ROBERT E. HANNEMANN, M.D.
Lafayette, Ind.
Private practice; specialty, pediatrics; research and teaching, Biomedical Engineering and Child Psychology, Purdue University; M.D. degree from Indiana University.



LeCLAIR BISSELL, M.D.
New York, N.Y.
Chief, Smithers Alcoholism Treatment and Training Center, Roosevelt Hospital, New York; Executive Board, American Medical Society on Alcoholism; member of Committee on Alcoholism and of Physicians Committee, Medical Society of State of New York; Carter Mental Health Commission Task Force on Alcoholism; M.D. degree from Columbia University.



NUHAD D. DINNO, M.D.
Louisville, Ky.
Associate Professor, Department of Pediatrics, and Chairman, Pediatrics Education Committee, University of Louisville School of Medicine; consultant for genetic abnormalities and birth defects; Diplomate, American Board of Pediatrics; M.D. degree from University of Baghdad, Baghdad, Iraq.



E. RICHARD DORSEY, M.D.
Cincinnati, Ohio
Private practice, psychiatry; Board of Directors, Emerson A. North Hospital, Cincinnati; Field Consultant in Peer Review, APA; Director of Psychopharmacology, Emerson A. North Hospital; certified, National Board of Medical Examiners, American Board of Psychiatry and Neurology (Psychiatry), American Psychiatric Association (Administrative Psychiatry); M.D. degree from West Virginia University.



CHARLES F. KEMPER, M.D.
Jeffersonville, Ind.
Private practice; specialty, pediatrics; Board eligible, American Board of Pediatrics, American Academy of Allergy and Immunology; M.D. degree from University of Louisville.

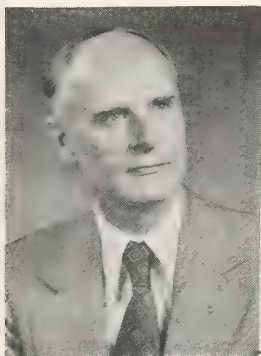


JACK A. CHEEK, JR., M.D.
Evansville, Ind.
Director, Perinatal Services, Welborn Baptist Hospital; Director, Areawide Perinatal Education Services; specialty, neonatology; Board Certified, Neonatal-Perinatal; M.D. degree from Duke Medical School.



JEFFREY ALEXANDER, M.D.
Indianapolis
Chief of Pediatrics, Riley Child Development Center, I.U. School of Medicine; specialty, pediatrics; M.D. degree from University of Illinois.

Guest Speakers



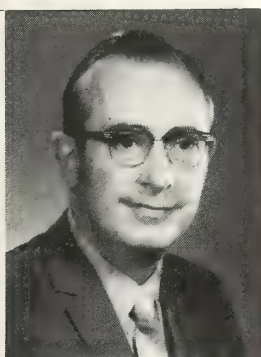
ALBERT G. J. CULLUM, M.D.
Middlesboro, Ky.

Private practice, principally microscopic reconstructive ear surgery; Diplomate, National Board of Medical Examiners; past chief of staff, Middlesboro Community Hospital; on staff, Kentucky State Commission for Handicapped Children; life member, AAPS; M.D. degree from New York College of Medicine.



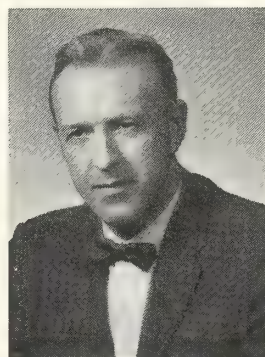
NED B. HORNBACK, M.D.
Indianapolis

Professor and Chairman, Department of Radiation Oncology, I.U. School of Medicine; director, research program in combination hyperthermia and ionizing radiation treatment for advanced cancer patients; member, national committees of American College of Radiology and American Society of Therapeutic Radiologists; M.D. degree from University of Wisconsin.



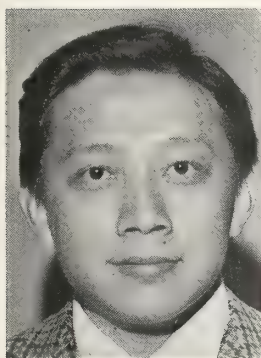
PHILIP L. WHITE, Sc.D.
Chicago, Ill.

Director, Department of Foods and Nutrition, AMA; for 18 years Secretary of AMA Council on Foods and Nutrition; has served in consultant capacity to a number of governmental agencies and food trade associations; founder and organizer of Western Hemisphere Nutrition Congress; Sc.D. degree from Harvard University.



HAROLD E. KLEINERT, M.D.
Louisville, Ky.

Clinical Professor of Surgery, University of Louisville, and Indiana University; Chief of Hand Surgery Services, University of Louisville Hospitals; consultant to the Surgeon General, U.S.A.F., Veterans Hospital, Louisville, Ireland Army Hospital, Ft. Knox, Ft. Campbell Army Hospital, and USAF Medical Center, Lackland, Texas; specialty in surgery of the hand; M.D. degree from Temple University.



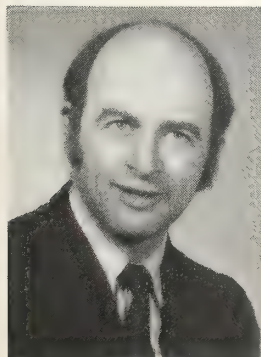
L. Y. FRANK WU, M.D.
Indianapolis

Clinical Assistant Professor, Department of Pediatrics, I.U. School of Medicine; specialty in allergy and asthma; Diplomate, American Board of Allergy and Immunology, and American Board of Pediatrics; M.D. degree from National Taiwan University, Taiwan.



JOHN C. PARTIN, M.D.
Cincinnati, Ohio

Director, Clinical Research Center, Cincinnati Children's Hospital Research Foundation; Associate Professor of Medicine, University of Cincinnati; diplomate, American Board of Pediatrics; member, American Association for Study of Liver Disease; M.D. degree from University of Cincinnati.



GRAHAM D. LISTER, M.D.
Louisville, Ky.

Assistant Clinical Professor of Plastic Surgery, University of Louisville School of Medicine; specialty, plastic surgery; M.D. degree from Glasgow University, Glasgow, Scotland.

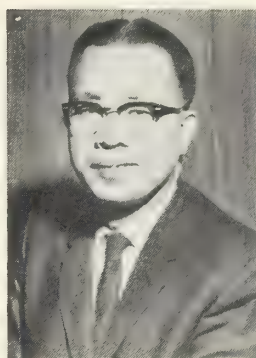


PAUL D. ISENBERG, M.D.
Indianapolis

Guest Speakers



JOSEPH F. FITZGERALD, M.D.
Indianapolis
Professor of Pediatrics and Director, Gastrointestinal Disease Section of Department of Pediatrics, I.U. School of Medicine; certified by American Board of Pediatrics; Fellow, American Academy of Pediatrics; M.D. degree from Indiana University.



WEI-PING LOH, M.D., Ph.D.
Gary, Ind.
Clinical Professor of Pathology, Indiana University School of Medicine; Chairman, Professional Education Committee, American Cancer Society, Indiana Division.



E. HARVEY ESTES, M.D.
Durham, N.C.



LEE G. JORDAN, M.D.
Indianapolis
Private practice in Gastroenterology.



ROBERT W. LUTHER, M.D.
Memphis, Tenn.
Instructor, Department of Surgery, and Chief, Hyperalimentation/Nutrition Support Service, University of Tennessee Center for the Health Sciences; Member, American Society for Parenteral & Enteral Nutrition (ASPEN); National Chairman of Membership Committee, ASPEN; Co-ordinator, Mid-South Region for Continuing Education; M.D. degree from University of Tennessee.



EUGENE D. VAN HOVE, M.D.
Indianapolis
Director, Nuclear Radiology, Methodist Hospital.



FRANK VINICOR, M.D.
Indianapolis
Director, Diabetes Clinic, Wishard Memorial Hospital; Associate Director for Training and Translation, Diabetes Research and Training Center, and Associate Professor of Medicine, Indiana University School of Medicine; Fellow, American College of Physicians; Chairman, Committee on Diabetes Detection and Public Education, and Member of Board of Directors, American Diabetes Association, Indiana Affiliate; M.D. degree from Washington University.



WILLIAM M. DUGAN, JR., M.D.
Indianapolis
Director, Clinical Oncology, Methodist Hospital.

Reports of Officers

Executive Director

This report, my third, to the House of Delegates and the members of ISMA happily finds the Association in sound financial condition as reflected in current operating statements. Membership has shown a steady increase and expenses have, for the most part, remained below budget. The financial report to be presented to you by the Treasurer at the ISMA annual meeting continues to reflect a gradual build-up of our liquid reserves. Such reserves form the basis for an adequate emergency reserve for meeting operating expenses in addition to the capability of meeting major challenges to the practice of medicine. You are well aware of the effects of inflation in your practices, and I must remind you that it is having the same insidious impact on the Association's finances. As time goes by, inflation inevitably will absorb more and more of the comfortable year-end reserves that we have recently been accumulating.

In attempting to strengthen its surveillance of federal activities and programs which threaten the fabric of private practice, ISMA submitted comments on numerous federal bills and proposed regulations. A successful coordinated effort was undertaken to prevent Congressional adoption of HEW's National Health Planning Guidelines in their original form.

At the invitation of the AMA, the ISMA sent a special delegation to Washington, D.C. to lobby members of the House Interstate and Foreign Commerce Committee on the proposed amendments to the Health Planning Act (P.L. 93-641), the extension of certificate of need to physicians' offices, and the various cost containment proposals.

In order to facilitate its stepped-up activity focusing on the federal level, the Board of Trustees earlier this year authorized the employment of an additional full-time attorney which also prompted a reorganization of ISMA staff. His principal role is to identify possible areas to challenge in federal programs and regulations that adversely impact the practice of medicine. Additionally, he is to provide advice and counsel to physicians participating in federally financed programs (HSAs, PSROs, etc.). Increased contacts and the development of working relationships have been initiated with Congressional as well as HEW staffers.

This year's session of the legislature, besides being a short session, was a relatively uneventful one. There was no chiropractic challenge to contend with and there were no major surprises from organized consumer groups. We were successful again in averting passage of certificate of need legislation and we are working hard to prevent its extension to physicians' offices being mandated in federal legislation. Particular vigilance will be required in dealing with legislative

proposals from other health professionals regarding scopes of practice. Federal reimbursement is now available to "Rural Health Clinics" for the services of physicians' assistants and nurse practitioners with minimum physician supervision consistent with state law.

Because of vigorous protests by ISMA and IHA to the Department of Public Welfare's rules and regulations implementing a Prior Approval Program for services to Medicaid beneficiaries, the Governor persuaded the Department's Administrator to withdraw the proposed regulations. The ISMA has spearheaded a multidisciplinary committee in rewriting the regulations which have been presented to the Governor's office for review.

Under the very able leadership of your president, ISMA assumed a leadership role in forming the Indiana Task Force on Cost Containment which is Indiana's counterpart of the National Steering Committee dedicated to promoting the "Voluntary Effort" program for containing health costs. The Indiana Task Force which is broadly based, like its national counterpart, includes representation from medicine, hospitals, health insurers, government, industry, labor, banking and consumers. The Task Force has met three times thus far and is making excellent progress in stimulating cost consciousness and implementing the objectives of the "Voluntary Effort."

Under a contract negotiated with the Indiana State Board of Health, your Association recently completed a most successful survey of specialized health services available in hospitals throughout the state. The response rate was most gratifying with approximately 80% of the institutions returning completed questionnaires. This was possible because of splendid cooperation from the chiefs of medical staffs and hospital administrators.

This year has witnessed the programming and phasing in of ISMA's own in-house computer system for membership. An IBM Systems 32 has been installed at headquarters and AMA's AM-CAP system has been terminated. The next dues bill sent to ISMA members will be generated and processed by ISMA's computer.

Consistent with House of Delegates' policy established at its 1977 meeting which declared ISMA's opposition to all insurance contracts containing a reimbursement (differential) provision for participating vs. non-participating physicians, ISMA registered a complaint with Indiana's insurance commissioner, citing the Vision Care Program of the United Auto Workers as an example. The insurance commissioner has responded and requested documentation of actual economic injuries suffered by patients and physicians resulting from par vs. non-par contracts. His request has been referred to Medical Eye Services of Indiana

Reports of Officers

(MESI) for further handling.

During 1977 the chairman of the Indiana Medical Education Foundation Committee initiated a meeting with the Executive Committee to discuss the need for reorganization of the Foundation's structure so as to insure more positive administrative control and to avoid any future legal complications. With the assistance of outside legal counsel and the cooperation of the Dean of I.U. School of Medicine, a new resolution amending the resolution that established the Foundation was drafted and presented for the Executive Committee's consideration. Essentially, this resolution (1) changes the name of the Committee from the Indiana Medical Education Foundation Committee to the Indiana Medical Education Fund, (2) establishes a new committee structure, and (3) fixes responsibility and reporting. It was recommended that regular reports of financial condition of the Fund be made to the Executive Committee in addition to an annual report to the House of Delegates. Such a report will be presented at this year's annual meeting.

Medical Protective Company has indicated that effective September 1, 1978, it will no longer charge an additional malpractice insurance premium differential for those physicians who have had suits filed against them. However, overall premium rates will increase due to increases levied by the re-insurance market.

All ISMA members can be justly proud of the manner in which they are represented at AMA meetings by Indiana delegates and alternate delegates to the AMA. Under able leadership, the delegation has achieved great credibility and rapport with the AMA House of Delegates. This acceptance was no doubt largely responsible for the election of two of Indiana's delegates, Peter Petrich, M.D., and Malcolm Scamahorn, M.D., to the Council on Constitution and Bylaws and the Council on Medical Services respectively at the 1978 AMA annual convention. It is obvious to most observers that Indiana's influence in the AMA House of Delegates is far in excess of the number of votes it casts.

Headquarters is constantly seeking ways in which to improve the timeliness of communications with the membership. During the last legislative session we launched a weekly legislative update (newsletter) which we plan to continue. Any ideas or suggestions for improving communications are most welcome.

As far as national health insurance is concerned we can expect the emergence this fall of a Carter Administration initiative, if not a bill. But what sort of proposal this will be remains to be seen. There are strong forces pushing for a broad, maximum approach and strong forces pushing for a minimal bill. Actually there is only one thing certain regarding health insurance legislation—it will begin to heat up as a politi-

cal issue late this year. It is interesting to note, however, that the once-solid support of the academic community for large federal health programs has been shattered by a wave of intellectual pragmatism that has sharply challenged the traditional liberal dogma that the solution always lies with the government. A prime example of this change has been the dwindling support for labor's national health insurance plans to federalize the health care system. Few academicians now stand to defend this broad approach, as once they stood solidly behind such proposals as Medicare and the now-defunct regional medical program.

Even more significant are the results of a recent study commissioned by Hospital Affiliates International, Inc., a subsidiary of INA Corporation, to provide an up-to-date, detailed analysis of how the American public views hospital care. While six out of seven people who had ever been hospitalized indicated they were satisfied with the quality of care they had received, a consensus exists among the public that the need to control costs and provide health care to those who cannot afford it is the number one priority for change. The survey disclosed that by 46% to 38% the public is against government regulation of hospitals. More importantly, the public disapproves of strict regulation in any area of hospital decision-making and they overwhelmingly oppose—by 85%—regulations which would inhibit the prerogatives of physicians.

DONALD F. FOY
Executive Director

Chairman, Board of Trustees

During the 1977-1978 year of activity the Board of Trustees devoted seven weekends and long hours of deliberation to a broad cross section of matters of importance to the membership.

In this report I will highlight some of the important matters the Board considered and took action upon. Although this report does not begin to cover all the actions of the Board, the minutes of our Board meetings are always open to any member who wishes to review them.

AMA MEETINGS: Board was briefed in detail by AMA delegates and alternate delegates prior to the annual and clinical sessions of the AMA and, in a number of instances, gave direction to the delegation as to how they should vote on specific resolutions and reports which were to come before the AMA House. The Board also directed the delegation to support a number of Indiana candidates for offices on AMA Councils, and this was accomplished successfully.

STUDENT ASSISTANCE: Offered financial assistance to a student representative to attend the Student Business Session of the AMA.

Reports of Officers

NATIONAL GUIDELINES FOR HEALTH PLANNING. Condemned the National Guidelines for Health Planning in that they potentially could cause the closing of small rural or community hospitals and, in addition, directed staff and trustees to visit each Indiana Congressman's office to explain ISMA's position and philosophy.

USE OF DRUGS BY OPTOMETRISTS: Expressed ISMA's concern and disapproval to the Medical Licensing Board that the use of drugs by optometrists is the practice of medicine and that, in instances wherein the Licensing Board knows that such is the case, action be taken against those involved.

DIFFERENTIAL REIMBURSEMENT: Took action to oppose all types of contracts that contain reference to differential reimbursement for participating vs. non-participating physicians.

NOMINATIONS FOR BLUE SHIELD BOARD: Selected nominees for members at large of the Blue Shield Board through a process of interviews and discussions.

COMMERCIAL EXHIBITS: Authorized the staff to solicit commercial exhibits for the annual convention.

SPORTS AND MEDICINE: Endorsed the Indiana Sports Medicine program and allocated \$4,000 seed money to initiate the program in Indiana.

DATA PROCESSING: Endorsed the Data Processing Steering Committee's approval in principle of ISMA's involvement in meeting the data processing requirements of the various Indiana PSROs. Requested the ISMA legal counsel to research the status and potential use of I-MEDIC as a mechanism for accommodating future ISMA computer applications.

ISMA POLICIES: Directed the staff to compile by the annual meeting in October a reference guide index of ISMA policies established over the past five years. Staff is in process of completing the task.

DISTRICT CONSTITUTIONS: Directed the staff to obtain constitutions and bylaws of each district medical society and develop model bylaws which the districts can adopt and use as guidelines.

ISMA AUXILIARY: Heard periodic reports from the president of the Auxiliary on its current activities.

MEMBER INSURANCE: Approved an increase in the major medical maximum from \$250,000 to \$1,000,000 lifetime with no increase in premium for the Blue Cross-Blue Shield Plan A (first dollar coverage, full service policy including major medical). Also approved a \$250 deductible under Blue Cross-Blue Shield Plan B, major medical only.

EXCESS MAJOR MEDICAL INSURANCE: Approved continuing this program and approved resolicitation of ISMA membership for enrollment in the Group Term Life Insurance Plan. Also requested that

the insurance company obtain appraisal for an open enrollment for the substandard disability insurance program.

OPPOSITION TO NHI: Polled the ISMA membership on attitudes toward National Health Insurance. Majority of physicians voted against withdrawal of an AMA-sponsored bill in Congress.

ANNUAL WASHINGTON VISITATION: Planned and carried out with the Executive Committee the annual Washington visit with Indiana Congressmen.

DATA COLLECTION: Followed closely ISMA's first involvement with data collection through a grant from the Indiana State Board of Health. Data on specialized health services were collected from Indiana hospitals to assist the ISBH and its Technical Advisory Committees in developing criteria and standards. The rate of response from Indiana hospitals was most gratifying.

VIDEO TAPE RECORDER: Authorized the purchase of a video tape recorder to capture special TV commentaries on health issues and subsequent recirculation to county societies.

VISION CARE PROGRAM: Authorized a letter of formal complaint to the Indiana Insurance Commissioner objecting to Blue Shield's implementation of the auto workers contract that contained a vision care program benefit, which the Board of Trustees felt was in violation of Indiana insurance law because of the par vs. non-par clause in the contract.

SECOND SURGICAL OPINIONS: Opposed the concept of mandatory second surgical opinion and advised Blue Cross and Blue Shield of this stand.

STATE PSRO COUNCIL: Directed the ISMA through I-MEDIC or through a group of interested persons associated with ISMA to attempt to maximize its influence in the formation of a statewide PSRO Council.

NATIONAL HEALTH SERVICE CORP: Worked in conjunction with county medical societies in placement of physicians through the National Health Service Corp. (NHSC).

LEGISLATION, NEGOTIATIONS, ETC.: Through reports from other offices and periodic guest presentations, the Board was kept abreast of arbitration and negotiations, planning activities, state and national legislation, progress of the special Cost Containment Committee and numerous other activities involving commissions and committees of the Association.

FEDERAL INVESTIGATIONS: Registered an objection with the Indiana State Board of Health for federal scrutiny for medical reasons of Indiana communities without notification of county medical societies.

SEPARATION FROM BLUE SHIELD: Considered the proposal of separation from Indiana Blue Shield, and subsequently adopted a resolution by the

Reports of Officers

Board that commended the history and beneficial actions of Medical Mutual Insurance Company and its Board in providing the best health care benefits for its policy holders and urged continuation of these achievements.

MARTIN J. O'NEILL, M.D.
Chairman, Board of Trustees

Executive Committee

Prior to the July 15, 1978 deadline for reports to the House of Delegates, the Executive Committee had met seven times and anticipated several additional meetings prior to the convention. Consequently this report will contain highlights of some of the committee's considerations to date as follows:

1. Routinely reviewed the financial condition of the Association and authorized investment of funds.

2. Completed review of the employees pension plan and authorized its continuation in conformity with government regulations.

3. Approved and/or disapproved numerous requests for the ISMA mailing list for a broad variety of programs and purposes.

4. Made liaison appointments to a number of health related organizations to insure official medical organization representation. Gerald Johnston, M.D., for example, was named to the Project Advisory Committee of the Indiana Department of Health.

5. Rejected the Louisiana State Medical Society's request for financial support of its "Doctors of Concern" program, designed to provide physicians with an analysis of the proposed AMA NHI legislation.

6. Recommended to the Board of Trustees that ISMA continue to oppose all types of contracts that contain references to differential reimbursement for participating vs. nonparticipating physicians.

7. Continued surveillance of legal fees and activities relating to ISMA outside legal consultants.

8. Recommended to the Board that the Impaired Physician Committee remain a committee at this time and that the president be encouraged to appoint, on a geographical basis, members to serve on the committee in an advisory capacity.

9. Approved a resolution amending the original resolution that established the Indiana Medical Foundation, which changed the structure of the Foundation to insure more positive administrative control and to avoid any future legal complications. A complete report regarding the status of the Foundation (Fund) will be presented to the House of Delegates at the October 1978 meeting.

10. Reviewed draft comments on Criteria and Standards for Acute Inpatient Care Facilities and services in Indiana, and authorized their submission to

the Indiana State Health Planning and Development Agency.

11. Authorized the temporary utilization of office space in the headquarters office by the Indiana Chapter of the American College of Emergency Physicians.

12. Requested the attorney general of Indiana to file an amicus curiae brief in favor of the North Carolina and Nebraska suits, which challenged the constitutionality of PL 93-641, National Health Planning and Resources Development Act of 1974.

13. Approved a staff reorganization.

14. Authorized staff to investigate proceedings for terminating the Student Loan Program.

15. Reviewed a staff-developed report on the origin, development and current relationship with Indiana Blue Shield (Mutual Medical Insurance, Inc.) as a result of action by the 1977 House of Delegates, and recommended to the ISMA Board of Trustees that ISMA continue to maintain its present association with the Blue Shield Board and that the current ineffectiveness of ISMA's association with the Blue Shield Board be improved.

16. Investigated properties for sale and lease that would offer expanded office space for future ISMA activities.

17. Recommended that ISMA study the independent CME accreditation program being conducted by the California Medical Association with a view toward establishing a similar program in Indiana.

18. Reviewed requests for medical defense from members and made appropriate disposition of such reports.

JOHN W. BEELER, M.D.
Chairman

JOE DUKES, M.D.

ARVINE G. POPPLEWELL, M.D.

JOSEPH F. FERRARA, M.D.

JAMES A. HARSHMAN, M.D.

ELI GOODMAN, M.D.

MARTIN J. O'NEILL, M.D.

RICHARD INGRAM, M.D.

Reports of Officers

Treasurer

The detailed report of the financial condition of the Association on September 30, 1978 will be made available for the Reference Committee prior to the annual meeting, along with a report of the anticipated budget for 1978-79. Being published at this time is the statement as of June 30, 1978.

If one extends the estimated remainder of expenditure for the rest of this year, the total expenditure anti-

cipated at the end of the year as of September 30, 1978 is expected to provide an income again over the expense. At this point it is anticipated at being approximately \$105,000 for all funds. For the general fund itself, we are expecting an anticipated increase of approximately \$80,000.

Over the past few years we have made an attempt to increase the balance in the general fund and to decrease the number of special funds that we have to

INDIANA STATE MEDICAL ASSOCIATION

Statement of Financial Condition

ASSETS

	6/30/78	9/30/77
GENERAL FUND:		
Cash on deposit	\$ 33,176	\$ 49,583
Investments at cost:		
U. S. Treasury Bonds-long term	60,122	35,070
U.S. Treasury Bills, Certificates of Deposit-short term	1,084,834	769,156
Accounts receivable	56,981	44,718
Prepaid expense and miscellaneous assets	13,981	15,661
Office furniture and equipment-net of accumulated depreciation	20,434	21,929
	<u>1,269,528</u>	<u>936,117</u>
BUILDING FUND:		
Cash on deposit	2,979	1,758
Cash in savings account	—	8,576
U.S. Treasury bills	303,059	278,562
Prepaid and deferred expenses	896	439
Headquarters property:		
Land	69,188	69,188
Office building and improvements-net of accumulated depreciation	214,794	216,625
Rental properties—net of accumulated depreciation	72,444	74,611
	<u>663,360</u>	<u>649,759</u>
STUDENT LOAN FUND:		
Cash in savings account	—	19,190
U.S. Treasury Bills	19,190	—
Certificates of deposit	20,810	20,810
	<u>40,000</u>	<u>40,000</u>

MEDICAL DEFENSE FUND: (Closed to the General Fund)

Cash in savings account	—	44,414
U.S. Treasury Bonds	—	25,288
	<u>—</u>	<u>69,702</u>

MEDICAL EDUCATION FUND:

Investments	354,179	354,179
	<u>354,179</u>	<u>354,179</u>
	<u>\$2,327,067</u>	<u>\$2,049,757</u>

LIABILITIES AND FUND BALANCES

	6/30/78	9/30/77
GENERAL FUND:		
Accounts payable	\$ 1,062	\$ 25,457
Accrued taxes	—	134
Dues payable to AMERF	21,855	21,788
Dues payable Counties, Districts, AMA	11,948	—
Unearned portion of current year dues	381,016	190,640
Deferred annual meeting income	6,625	3,050
Deferred Journal income	3,500	—
Fund balance	843,522	695,048
	<u>1,269,528</u>	<u>936,117</u>
BUILDING FUND:		
Accrued taxes on rental properties	738	952
Damage deposits and accounts payable	690	2,052
Loans from members (Non-interest bearing)	6,150	7,750
Fund balance	655,782	639,005
	<u>663,360</u>	<u>649,759</u>
STUDENT LOAN FUND:		
Fund balance—principal balance appropriated from General Fund	40,000	40,000
	<u>40,000</u>	<u>40,000</u>

MEDICAL DEFENSE FUND:

Fund balance (Closed to the General Fund)	—	69,702
	<u>—</u>	<u>69,702</u>

MEDICAL EDUCATION FUND:

Committed to Indiana University	354,179	354,179
	<u>354,179</u>	<u>354,179</u>
	<u>\$2,327,067</u>	<u>\$2,049,757</u>

Reports of Officers

keep. As a result, only the student loan fund, building fund and general fund now exist. The remainder of the funds belonging to the Association have been amalgomated into the general fund. For an association of this size there has been a general feeling that we should try to eventually arrive at a general fund balance of \$1,000,000, which would be slightly over one year's operating fund. This would allow in any one year the Board of Trustees to meet emergencies that might come along in the way of legislative activities, or our new public relations program that is felt to be necessary on a one-time basis. It would appear that if we are confronted with expenses that are going to provide an ongoing obligation requiring dues increases, that these then need to be brought forth at our annual meeting.

In 1975 the general fund balance was \$292,110; the medical defense fund at that time was \$56,000 and that, of course, has now been amalgomated.

In 1976 the general fund balance, together with the medical defense fund, was \$575,690.

In 1977 we finished with a fund balance of the now general fund of \$764,750.

Currently, the anticipated budget for 1978-79 has been prepared so that no increase in dues is necessary unless recommendations from the House of Delegates on resolutions with budgetary significance are passed.

It has been a distinct pleasure serving our association first as assistant treasurer and now as treasurer. I want to thank other members of the Board of Trustees and the Executive Committee and members of the staff of our Association for their assistance during the year.

ARVINE G. POPPLEWELL, M.D.
Treasurer

American Medical Association Delegation

The Annual Convention of the American Medical Association was held in St. Louis June 18, 1978 through June 22, 1978 and a full contingent of Indiana's delegates and alternate delegates was in attendance.

In addition to closely following the proceedings of the House of Delegates and participating in debates on the floor, the Indiana contingent accomplished the election of two of its delegates to important councils of the AMA. Peter R. Petrich, M.D. was elected to the Council on Constitution and Bylaws and Malcolm O. Scamahorn to the Council on Medical Service, both to three-year terms.

Highlights of the House of Delegates included the following:

Report of National Commission on Cost of Medical Care: The delegates accepted major portions of the Report of the National Commission on the Cost of

Medical Care, and agreed to give other recommendations further study.

They rejected one cost commission recommendation by reaffirming AMA policy. The recommendation called for physicians and others to reach agreement on the reasonableness of levels of reimbursement. Delegates reaffirmed the policy that fee information should be available to the patient, and that ability to pay should be considered. They also reaffirmed the opposition to the use of uniform fee schedules.

This was the only commission recommendation neither approved nor referred. The comprehensive document, which attempts to elucidate factors responsible for escalating health care costs as well as recommend methods to contain them, caused some confusion as delegates grappled with language they had not written and could not change.

The commission was sponsored by the AMA, but its report was independently prepared by the 27 commission members, including representatives from health care providers, government agencies, business and labor.

New President's Comments: Tom E. Nesbitt, M.D., new president of the American Medical Association, urged all physicians to cut the rate of their professional fee increases over the next two years.

Dr. Nesbitt called for voluntary restraints during his inaugural address. He stated that such restraints would help combat the Administration's attempt to impose a national health service on the public. "We physicians, after all, are not exempt from the hard realities of today's economy . . . from the general inflationary spiral. And these added costs necessitate periodic increases in our professional fees. What each of us can do, however, is place realistic restraints on the rate of these periodic increases while maintaining the quality of patient care."

Dr. Nesbitt suggested that physicians should cut the rate of their fee increases by 1% each year for the next two years. He noted that these restraints would reinforce an "existing downward trend in the rate of increase of physicians' fees" and bring the fee escalation rate close to the "all-items" rate on the Consumer Price Index, or "perhaps under it, if recent all-items price increases continue."

Dr. Gardner, President-Elect: The American Medical Association's new president-elect, Hoyt D. Gardner, M.D., a Louisville, Ky., general surgeon, will use the presidency as a platform "to go back to the grassroots and promote professional unity."

In his first press conference after election, Dr. Gardner said, "The presidency is a great symbol the Association can use to reach out and touch its members and be touched in return."

Turning to the chief issue at this year's annual con-

Reports of Officers

American Medical Association Delegation

vention, Dr. Gardner said he thought "America's physicians will support the recommendation of the National Commission on the Cost of Medical Care. . . . Physicians are objective and they tend to be very responsive once they are aware of a problem."

Principles of Medical Ethics: The House of Delegates asked the Judicial Council to reconsider its proposed revision of the Principles of Medical Ethics. What had seemed likely to be one of the most contentious issues at the AMA annual meeting was put aside for further consideration. An ad hoc committee of the house was created to study the matter, and was asked to report back to the house at the next meeting.

Health Planning: Medical societies must become politically active and involved in all levels of the planning structure, the Delegates stated. AMA also opposed proposed regulations for the composition and selection of HSA governing bodies and opposed proposed rules on appropriateness review by HSAs and State Health Planning and Development Agencies. AMA's Council on Legislation is preparing comments on these regulations.

A report adopted by the house summarized activities of the Council on Medical Service's ad hoc committee on health planning and updated recent developments in the field.

The report recommended the following principles for effective medical society participation in planning activities:

- Closely monitor the Health Systems Plan and the Annual Implementation Plan development activities and provide appropriate comment to the HSA during each stage of development.
- Establish state and local physician bodies to monitor HSA activities and to respond to HSA actions on behalf of the health service area's medical community.
- Maintain dialogue with other medical societies in regard to their efforts, strategies, and ideas in response to implementation of PL 93-641.
- Draw upon individuals with expertise for interpretations of the planning law's provisions.
- Provide adequate staff to monitor and analyze HSA activities and to ensure distribution of all appropriate planning materials to concerned physicians.
- Work to assure the appropriate exclusion of physicians' offices from review.
- Monitor the use of data and assist PSROs and HSAs in interpreting data.
- Consider entering into agreements with HSAs to assure ongoing medical input and coordination with local planning activities.
- Establish programs to keep consumers better informed.

- Identify and disseminate information on any adverse effects to patient care as a result of the application of the planning law or its regulations.

National Health Insurance: National health insurance, the issue that has dominated recent sessions of the AMA House, was put on hold at the convention. It will return, however, at this winter's Interim Meeting. Debate was relatively brief and subdued both before the reference committee and house, as delegates directed the Board of Trustees to determine if a new or substitute bill for HR 1818, the Comprehensive Health Insurance Act of 1977, "is necessary or not." If it is, the house directed, and "if an AMA-sponsored NHI bill is to be submitted at the Interim Meeting, it should be circulated to the members of the house as early as possible so it may be studied in detail before that session."

The house, in effect, asserted its prerogative to approve the precise language of any NHI bill that might be submitted to the new Congress by AMA, a development that heretofore has been for all practical purposes, determined by the Council on Legislation.

PSRO Action: AMA vigorously opposed any attempt to mandate the use by PSROs of national criteria without allowing for local amendment, modification, or adaptation.

Criteria should be used for screening purposes only, subject to peer review, a resolution adopted by the House of Delegates said. The resolution noted that the National PSRO Council has created guidelines relative to the 11 most commonly performed surgical procedures with plans calling for expansion to include criteria for more than 100 additional surgical procedures by Jan. 1, 1979. In making its recommendation, the reference committee noted that the guidelines will be offered only as sample screening criteria, for use or adaptation by individual PSROs at their discretion.

Bypassing Medical Staff Bylaws: The AMA opposed any unilateral action of hospital boards of trustees that alters or bypasses previously adopted and approved medical staff bylaws, rules, and regulations.

The resolution approved by the House of Delegates also supported the right of all medical staffs to conduct the practice of medicine in all facilities according to the rules and regulations governing the staffs as set forth in the bylaws, rules and regulations drawn up and adopted by the medical staffs and approved by the governing body.

In-Office Insurance Coverage: The AMA will urge the Blue Cross-Blue Shield Assn. and the Health Insurance Association of America to refrain from providing policies that penalize patients for selecting their physicians' offices for performance of medical and surgical procedures.

Reports of Officers

American Medical Association Delegation

The resolution approved by the AMA House of Delegates is aimed at insurance companies that provide policies that pay for medical or minor surgical services when rendered in the hospital emergency rooms but not in physicians' offices.

In related actions, the house opposed the current Presidential recommendation to increase the exclusion from allowable deductions for medical expenses from 3% to 10% for Internal Revenue Service purposes.

CME Accreditation: The House rejected a proposal to recognize state medical societies as the only authorized agencies for accrediting continuing medical education programs.

The action means the state societies will continue to have the right to conduct surveys of CME programs and make recommendations for accreditation, but the Liaison Committee on Continuing Medical Education (LCCME) will have the responsibility for making the definitive decision.

Student Loans: Student loans are getting scarcer at a time when the cost of medical education is soaring.

Some lending institutions are cutting back on loans to medical students as a result of an increased rate. To meet the soaring demand for assistance, AMA officials announced during the St. Louis convention plans to limit to 50 the number of students at any medical school who may obtain guaranteed loans from the AMA Education and Research Foundation. A California delegation resolution calling on the AMA to take a position that it is unethical for any physician not to repay his or her educational loan was referred to the Board of Trustees for study and for developing recommendations to discourage defaults.

Healthier Lifestyles: The House took positive actions on several resolutions that suggested that the public has been lax about maintaining its personal health and so needs education on healthier lifestyles.

For example, the delegates endorsed the use of crash helmets as "the single most effective countermeasure to severe or fatal head injury in motorcycle-related crashes."

Delegates from New York, Indiana, Maine and the American Academy of Pediatrics all rose to support the report of the Council on Scientific Affairs, which recommends that any person riding a motorcycle wear a properly fitted full-facial helmet and that this statement be distributed to all appropriate safety and motorcycle organizations.

Jail Project: The expansion of the American Medical Association's jail health program was announced during the annual meeting. Nine states and the District of Columbia will be included in the program, funded by a Law Enforcement Assistance Administration grant and designed to upgrade jail health care by providing

states with minimum health and medical standards for the jail setting. Illinois, Massachusetts, Nevada, Ohio, North Carolina, Pennsylvania, South Carolina, Texas, Washington, D.C. and one state as yet unnamed will join the six pilot states already using the standards developed by the AMA's Jail Health Project two years ago. The six pilot states are Georgia, Indiana, Maryland, Michigan, Washington and Wisconsin.

AMA DELEGATION

Interim Meeting: Dec. 4-7, 1977

Chicago was the scene for the Interim meeting of the American Medical Association's House of Delegates, Dec. 4-7, 1977, at the Palmer House, and Indiana's delegation of officers, delegates and alternate delegates were in full attendance.

The Indiana delegation introduced five resolutions dealing with seconding nominations in AMA elections, AMA dues credit, council representation on reference committees, leadership in the American Blood Commission, and proficiency in advanced cardiac life support.

Seconding of Nominations: The resolution on seconding of nominations was amended and adopted by the AMA House. The Indiana delegation had asked that the seconding of nominations for all elected positions be eliminated. The reference committee recommended instead that the entire nomination and election procedure including seconding of nominations be examined by the Board of Trustees and their recommendations reported back to the 1978 Interim meeting of the House.

AMA Dues Credit: The AMA dues credit resolution stated that AMA members who have paid the special assessment be credited with \$60 toward their AMA dues the year following that time the American Medical Association reserve fund reaches an adequate level.

The reference committee recommended rejection of this resolution since no specific time frame was proposed by the resolution and stated that they would prefer that the AMA Board not be obligated at this time to a specific mechanism which would reduce AMA reserves. The committee pointed out that when and if such actions become feasible, the mechanism proposed by the Indiana resolution could be considered. As of Oct. 31, 1977, 151,819 members had paid a total of \$9,109,140.

Council Representation on Reference Committees: The AMA House rejected Indiana's resolution concerned with council representation on reference committees. The reference committee reported to the House that it believes the present system of selecting reference committees is fair and equitable. Adoption of the Indiana resolution, they said, would prevent 40 mem-

Reports of Officers

American Medical Association Delegation

bers of the House from serving on a reference committee.

The Indiana delegation had asked that a council member of the AMA not sit on a reference committee which was considering items presented by a council of which he is a member.

Leadership in the American Blood Commission: Leadership in the American Blood Commission resolution was adopted by the AMA House. The resolve stated that the AMA continue to play an affirmative leadership role in the activities of the American Blood Commission and the formulation and implementation of the National Blood Program.

Proficiency in Advanced Cardiac Life Support: On the matter of proficiency in advanced cardiac life support, the reference committee recommended amendment and adoption. The amendment did not change the intent of the resolution which resolved that the AMA recommend that all licensed physicians become and remain proficient in basic Cardio-Pulmonary Resuscitation (CPR) and also resolved that all licensed physicians become proficient in advanced Cardiac Life Support commensurate with their responsibilities in critical care areas.

Comprehensive Health Insurance: The vote was 4-1 (178-46) this time as American Medical Association delegates renewed their support for AMA-sponsored legislation on comprehensive health insurance. The arguments go back a decade and there was nothing new in the debate at the 1977 interim meeting.

Once again, Louisiana and its alternate delegate, F. Michael Smith, M.D., led the opposition against an AMA bill. Dr. Smith asserted that the proposed AMA bill would by 1980 cost \$196 billion, a figure "one-and-three-quarter times the total corporate profits of America."

Russell Roth, M.D., a past president of the AMA and the architect a decade ago of AMA's legislation for comprehensive health insurance (it was called "Medicredit" then), said, "I am pleased at these Louisiana figures about how much our bill will cost. The AMA should not be offering bargain-basement medical care."

Specialty Society Representation: After nearly three hours of heated debate, the AMA's House of Delegates totally revamped the section council system and set specific criteria for giving specialty societies direct representation in the AMA.

The actions eliminate delegates to the house from the 28 section councils and instead will enable any specialty society that meets the criteria to request the seating of its own delegate. The move is a major policy change that can greatly expand specialty society representation in the AMA, and in doing so

can provide a stronger, more united voice for American medicine, proponents said.

Blues' Policies: Delegates to the interim meeting resoundingly opposed the "participate or perish" practices of some Blue Shield/Blue Cross plans.

A report that was quickly accepted by delegates pointed to two new health insurance coverages, the so-called vision and hearing program—involving differential payment for the services of participating and non-participating physicians—as being responsible for recent weakening in the relationships between physicians and the plans. Delegates accepted the Board of Trustees' proposal to work with the Council on Medical Service and other AMA councils and committees in making an in-depth study of the problem, and reporting its findings at the 1978 Annual Meeting.

They also adopted a resolution urging the AMA to oppose third-party differentiation between covered services provided by participating and non-participating physicians as discriminatory against the physician who does not have a separate contractual relationship with the carrier, and as inhibiting the patient's free choice of physician.

The resolution also urged that the AMA position be communicated to all health insurance carriers.

Professional Standards Review Organizations: Professional Standards Review Organizations remained a focal point of discussion, with some half-dozen PSRO-related items acted upon by delegates to the AMA's interim meeting.

At the heart of physician concern was the essential purpose of the organizations. "Our concern should be with the HEW thrust to make PSROs something other than what they were originally intended to be," a delegate stated. "If they are to become agencies promoting second opinions for surgery, or organizations designed to root out fraud and abuse, their original purpose will be changed. PSROs were designed to assure quality of care. Necessity of surgery can be a legitimate concern of PSROs, but if they are to be molded into police agencies for federal programs they will not be following their mandate. Our job is to watch them carefully."

Responding to that position, delegates urged the AMA to conduct ongoing evaluation of the PSRO program to ensure that its primary focus remains on quality and appropriateness of care, rather than on cost containment or surveillance.

Delegates also urged that the AMA adopt the policy that physicians be reimbursed for all mandated PSRO activity, and that the level of reimbursement be negotiated by each PSRO, with no arbitrary dollar limit imposed by the federal government.

Legislation: AMA delegates approved a series of legislative amendments designed to stem the growing

Reports of Officers

American Medical Association Delegation

federal intrusion into medicine. The legislation, developed by the AMA Council on Legislation, and endorsed by the Board of Trustees, was in response to resolutions approved at the 1977 annual convention.

The proposed legislation would:

- Change the Health Professions Educational Assistance Act so that medical schools will not be required as a condition of receiving capitation grants to accept as third-year transfers U.S. citizens enrolled in foreign medical schools; and so that a proposed HEW health professions data system will not single out physicians and dentists as the first group about whom data will be collected.

- Assure that the Food and Drug Act continue to make available "safe and effective" drugs, while at the same time minimizing the time required to put drugs on the American market. Of special concern is Patient Informational Leaflets, which, delegates directed, should not be mandatory for all drugs.

- Assure adequate physician representation on health planning agencies and prevent the imposition of national guidelines for health planning. In a related action, the house directed the AMA to be prepared to join a state medical society's suit, should one legally challenge any state certificate-of-need law that includes physicians' offices.

- Place all government institutions, except for the military, under the same health planning, Professional Standards Review Organization, and other federally mandated health care requirements that are currently imposed—by federal law—upon private institutions.

- Assure the confidentiality of PSRO data.

- Prevent Medicare payments for physician extenders not under the direct supervision of a physician.

Guidelines for Medical Directors: Twenty-two suggested guidelines for physicians attending patients in skilled nursing and long-term care facilities were adopted by the AMA House.

The guidelines, prepared by the AMA Council on Medical Service, are intended to clarify the role of attending physicians in long-term care facilities, help them in maintaining a high level of care in these institutions, and assist them in working with the medical director to achieve that end.

The new guidelines supplement the 1973 "Guidelines for a Medical Director in a Long-Term Care Facility" and replace a 1959 report. The council noted that the guidelines should be taken as general suggestions only, and will need to be adapted to local conditions.

Marihuana: While echoing its long-standing position that there is "little conclusive evidence of long-term adverse consequences of marihuana use in the United States," and discouraging marihuana use, the House of

Delegates also said that "a criminal record is a handicap . . . for life" that can cause stress and anxiety, a "genuine medical concern."

The house urged that the penalties for possession of small amounts of marihuana be "modified," though criminal sanctions should still be imposed for drug trafficking.

This statement came at the heels of the recent call by both the AMA and the American Bar Association to decriminalize the laws concerning possession of marihuana nationwide. The house voted to support the position that "for healthy users intermittent ingestion of even relatively potent marihuana rarely constitutes a health hazard," but warned that "regular ingestion or multiple drug use might."

In advocating a "more realistic and humane legal approach," the house also said that modified laws should be "enforced vigorously and equitably so as to discourage use wherever possible and to reflect the continuing conviction that marihuana is not a harmless drug."

Patient Package Inserts: It is the prerogative of the physician to determine whether a patient receives an information leaflet with his prescription drugs, House of Delegates decided. This stand on patient package inserts (PPI) is a modification of the hard line adopted by the house at the 1977 annual convention, when it said that the AMA "opposed mandatory PPIs for all drugs."

Not all prescriptions require PPIs, the house said at its interim meeting, but when included, the information should "enumerate only selected, significant, documented side effects and adverse reactions" and avoid mentioning any bizarre contraindications.

It was also recommended that PPIs should not be developed unilaterally by the federal government, "but should represent a cooperative effort by the major organizations of medicine and pharmacy," the house said.

AETNA Health Advertising: The health advertising campaign of Aetna Life and Casualty Insurance Co. came under sharp attack at the Interim Meeting. Physicians complained of the abrasive and simplistic nature of the advertisements, and adopted a report expressing the deep concern as expressed to Aetna by the AMA. The report pointed out that the AMA has inaugurated a substantial advertising program designed to convey the positive accomplishments in medicine and health care.

Other Actions: In other actions the AMA House:

- Adopted a Board of Trustees report describing the joint AMA, AHA, FAH plan to develop a voluntary hospital and medical care cost containment program and urging state medical societies to establish

Reports of Officers

American Medical Association Delegation

joint state level committees with state hospital associations to implement such a program.

► Supported the concept that PSROs or other existing utilization committees make their own determinations as to what constitutes medical necessity for continued hospitalization.

► Adopted as AMA policy the JCAH standard that the hospital medical staff has the right to be represented by physicians elected by that staff at all meetings of the governing body.

► Endorsed the concept that physicians who perform services as the agent of a hospital corporation be properly covered by the hospital's liability insurance and asked AMA to seek immediate modification in hospital accreditation standards that unnecessarily expose physicians to personal medical liability in performing such services.

► Endorsed the development and mandatory installation of effective crash protection systems for motor vehicle occupants and advocated further study of the airbag as a mandatory component of new cars.

ELI GOODMAN, M.D.

President, and Chairman, AMA Delegation

JAMES HARSHMAN, M.D.

PATRICK J. V. CORCORAN, M.D.

PETER R. PETRICH, M.D.

MALCOLM O. SCAMAHORN, M.D.

ROSS L. EGGER, M.D.

DELEGATES

THOMAS C. TYRRELL, M.D.

MARVIN E. PRIDDY, M.D.

GEORGE T. LUKEMEYER, M.D.

GILBERT M. WILHELMUS, M.D.

EVERETT E. BICKERS, M.D.

ALTERNATE DELEGATES

state, THE JOURNAL has continued several series of clinical and historical writings and has initiated a new collection of articles written especially for purposes of continuing medical education.

The series of essays on hypertension, written by the various staff members of the Specialized Center of Research in Hypertension at Indiana University School of Medicine, has continued. Each of these presentations deals with a specific consideration in the study of the complex condition of hypertension and is written in as concise a fashion as possible. This series will continue in the coming year and may possibly extend into future years.

At least a part of the credits for continuing medical education may be obtained without closing the office and without large expenditure for tuition and hotel lodging. Indiana University produces clinical articles especially for CME purposes and underwrites the publishing cost. This series has developed into a most popular feature. These essays are accompanied by a multiple-choice quiz the completion of which, if satisfactorily performed, entitles the reader to one hour of CME credit. During the year the number of examinations returned for registration of credit has increased steadily. This feature will be continued in 1979.

Seminars from Riley Children's Hospital have been produced in adequate numbers to outline the diagnosis and treatment for conditions of critical nature in newborns and infants. In addition, information on the routine diagnosis of PKU and hypothyroidism in the newborn has been published in a timely manner.

Medical history in Indiana has been covered by the periodic reports of Dr. Charles A. Bonsett and by a unique letter of historical significance from the pen of Dr. W. N. Wishard, Sr.

Special coverage has been provided for the diagnosis of scoliosis in school children. Legionnaire's Disease has been expounded.

A new human interest series features interesting biographical facts relating to various renowned members of ISMA.

The editorial policy of limiting scientific articles to the space of two journal pages whenever possible has resulted in more concise writing and as a result has increased readability and interest. We go into 1979 with an adequate supply of clinical material and with hopes of shortening the waiting time to publication.

FRANK B. RAMSEY, M.D.
Editor

Editor, The Journal

Financial accounts for THE JOURNAL at the end of the third quarter of the fiscal year indicate that, while the individual items of the budget have varied from predictions, the balance is close to even. Example: Journal income other than dues is up by \$8,000—printing expense is up by the same amount. Also: Number of pages printed is up by 19.3% and the number of copies printed is up by 4.8%. To offset the increased production has required only a 13.7% increase in the amount subsidized by members' dues. Business transacted in the fourth quarter may alter these proportions, but the difference should not be significant.

In addition to an ample supply of clinical articles submitted by ISMA members from all regions of the

Reports of Commissions

Commission on Medical Services

The Commission on Medical Services (CMS) has progressed in 1978 to the point where some of the benefits hoped for from the merger of many preexisting commissions are being reaped. CMS members are drawn from the classic ISMA District selection plus two at-large members which has yielded a rich mixture of rural, middle and heavily populated area practitioners and doctors of all ages, stages and types of practice. From this parent group we have been able to identify doctors with specific interests and experiences to study and make recommendations on specific subjects to the entire commission for its reactions and further recommendations. This approach has been successful in many cases; but the projects that have *failed* or *faltered* deserve more study to improve the methods for finding better ways to match up ISMA members with the problems of our times and the speculations of the future.

The Subcommittee on Sports and Medicine over the past two years was well on the way to developing an active role for ISMA to relate organized medicine to leadership and ongoing educational roles in health and physical fitness programs for Indiana Schools. Through the process of discussion and reinterpretations of previous CMS, Board and House of Delegates actions and resolutions, the ISMA position was changed to one of endorsing and making a contribution to a newly formed Indiana organization having only minimal relationship with organized medicine. This situation should be regularly reviewed in the coming years and ISMA's position reviewed and possibly revised.

The Subcommittee on Aging has held many well attended meetings to evaluate the need for an Indiana medical organization of non-hospital care institution administrative M.D.'s. Reports to CMS by its able Subcommittee Chairman, Dr. A. Donato, recommended the need to organize this group of M.D.'s into a Subsection of the ISMA. CMS endorses and recommends passage of Res. 78-1 to establish an ISMA Specialty Section of Medical Directors and Staff Physicians of Nursing Facilities.

The Subcommittee on Insurance composed of a small M.D. group with excellent staff support has been able to make realistic evaluations of current ISMA members' insurance programs. The Subcommittee has been particularly active in analyzing the Blue Cross-Blue Shield plans. *Master* policies have been obtained; negotiations and renegotiations have provided our participating members with the best insurance choices possible in the context of inflationary times. These activities have helped to conserve the time of our hard-working Board of Trustees. Because the en-

tire CMS was at some time involved in the insurance studies, ISMA now has a number of members more knowledgeable in this important area who can serve the Association as a resource in the future. CMS is evaluating new benefit options such as dental and visual indemnification plans.

The interrelationships of medical services, data systems and analyses, ISMA, government medical programs (Medicaid, Medicare, HMO, PSRO, HSA, etc.), are most difficult to organize for evaluation and proper reaction. CMS has studied these interrelationships as a committee of the whole.

PSRO: CMS has recommended technical aspects, such as data operations, should be monitored by an organization such as I-Medic while policy matters such as the development of a Statewide PSRO Council are matters of ISMA concern. *CMS offered the board criteria and possible methods for use in determining nominees to the Statewide PSRO Council.*

HMO: The situation is too fluid. Some states and areas are beginning to organize significant Independent Practice Associations (IP) or HMOs without walls. Continuing study is needed but probably no action or policy position is indicated at present.

MEDICAID: Resolution 77-33 was submitted by CMS with the whereases and resolves giving high priority to data and systems analyses of such non-ISMA data as Medicaid and private usual and customary programs. An appropriation to implement this resolution has not been forthcoming, but rather has been diverted into hiring an attorney with stress on PSRO and HSA and no mention of current data study needs mentioned in Res. 77-33. All of our membership must become aware of the mushrooming effort of the Government to federalize Medicaid completely. This is a multipronged federal effort that can be stymied only by having accurate data analyses. HEW now implies that Blue Shield intermediaries having a predominance of M.D.'s as Board members may be in a position to manipulate provider payments.

This seems rather strange since HEW imposes strict parameters on payments to providers for care rendered to federal beneficiaries. *If ISMA had the analysis available* it would be able to provide our legislators and media with information indicating that while Indiana Medicaid is not *ideal*, it is more efficient, economical and non-manipulated than in most other states. CMS feels for many reasons the implementation of 77-33 with regard to data analysis should be given a higher priority in ISMA affairs.

The Commission spent a fair amount of time evaluating the need for semi-professional spokesmen (M.D.) for specific roles in representing ISMA. This need is developing for some of the following reasons: (1) The number of meetings requiring M.D. profes-

Reports of Commissions

sional interpretation and testimony is growing. (2) In-House (ISMA) continuing medical expertise to blend with lay staff talents is becoming desirable if not necessary. (3) More Commissions, liaisons and task forces are being formed that could benefit from ongoing MD participation. (4) More bodies such as HSAs, legislative and governmental commissions may require reliable M.D. testimony. CMS has developed some needs for such a program of semiprofessional spokesmen, written job descriptions, and analyzed why we wouldn't or couldn't assume a full or part time organizational position. Financial considerations were particularly evaluated. The results of this effort are embodied in Resolution 78-6 which we recommend passage of as an initial step for development of the concept of semiprofessional staff M.D. spokesmen.

The Co-Chairman undersigned wishes to thank the many active Commissioners who gave of themselves in Commission and Subcommission deliberations. I, for one, have been enriched by the experience of serving and would encourage ISMA members to seek Commission service as a means of serving your patient, organization and discovering yourself.

LEE H. TRACHTENBERG, M.D.

JACK HANNAH, M.D.

Co-Chairmen

WALLACE M. ADYE, JR., M.D.

DONALD DEAN COFIELD, M.D.

EVERETT E. BICKERS, M.D.

ROBERT O. ZINK, M.D.

PAUL E. HUMPHREY, M.D.

ROBERT R. TAUBE, M.D.

ALBERT DAONATO, M.D.

THEODORE R. HAYES, M.D.

GARY BOUGHER, M.D.

R. JAMES BILLS, M.D.

REGINO B. URGENA, M.D.

R. WYATT WEAVER, M.D.

ROBERT R. KOPECKY, M.D.

HAROLD MARSHALL TRUSLER, M.D.

RICHARD B. SCHNUTE, M.D.

Commission on Medical Education

Three scheduled meetings of the sub-commission on CME accreditation and three scheduled meetings of the full Commission were held at ISMA Headquarters during the reporting period (F.Y. 1978).

1. 1978 marked the beginning of changes in CME accreditation with the AMA and ISMA accreditation authority being assumed by the Liaison Committee on Continuing Medical Education (LCCME). The latter was formed to provide broader representation as an accrediting agency. The LCCME is composed of representatives of:

The Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, Council of Medical Specialty Societies, Association of Hospital Medical Education, Federation of State Medical Boards in the U.S., Inc., the public and the Federal Government.

Transition from our relationship with the AMA in accreditation to LCCME has been without incident and all of our recommendations for accreditation have been accepted. A delay inherent in the new system contains the potential to diminish physician interest in CME. It can now take six to nine months, after a site survey, for a hospital to be accredited.

2. During the reporting period the following hospitals were "site surveyed" for initial accreditation or re-surveyed for extension of accreditation (asterisk denotes reaccreditation):

Bloomington Hospital*

Terre Haute Union Hospital*

Howard Community Hospital—Kokomo

St. Vincent Hospital—Indianapolis*

Bartholomew County Hospital—Columbus

St. Johns Hickey Memorial Hospital—Anderson

Dearborn County Hospital—Lawrenceburg*

Deaconess Hospital—Evansville*

Reid Memorial Hospital—Richmond*

Mercy Hospital—Elwood*

Ft. Wayne Medical Society Medical Education Foundation, Inc.*

3. Institutions other than hospitals surveyed for CME accreditation were (asterisk denotes reaccreditation):

Ft. Wayne Academy of Medicine and Surgery

Indiana Association of Pathologists*

Wright Institute of Otolaryngology, Inc.*

Aesculapian Society of Wabash Valley—Terre Haute*

Indiana Society of Anesthesiologists*

Hawley Army Health Clinic, Fort Benjamin Harrison

4. All hospitals in Indiana, other than those already having known CME programs, were offered, at no cost, the handbook, "How to Start a CME Program in Your Hospital," prepared by L. S. Stein, Ph.D., of the Illinois Council on CME. Thirty-four hospitals, through their administrator or chairman of medical education, made requests for the book.

5. In a similar action, ISMA Commission on Medical Education sent two handbooks, purchased by the Commission, to all Indiana CME accredited hospitals. These, also issued by Dr. Stein's organization, were

Reports of Commissions

titled "Case-Discussion and Problem Solving" and "Patient-Problem Inventory—Planning CME Programs."

6. Scientific programs of the ISMA state convention were reviewed by the Commission and assigned hour for hour credits for the Physician's Recognition Award. Cards were available at the convention to allow the physician to record the hours of attendance at each accredited program. Cards were subsequently validated and returned to the physician by mail for his CME records.

7. To enable the Commission to be abreast of CME changes, Dr. Eugene M. Gillum was authorized as ISMA's representative to meetings of the National Council of State Committees on CME (NCSCCME).

8. Computerization of CME records for all physicians repeatedly comes to the Commission's attention. AMA has been working on a program for five years, and it is yet to be announced. Several hospitals have computerized records of *their own programs* where they have complete control. ACFP has a computerized program under a limited test in five states. It is encountering many problems, as might be expected.

The Commission was asked for its attitude toward CME computerized records. Its conclusion was that there are grave doubts about such a program, especially its enormous cost. It further concluded that ISMA not attempt to undertake a CME record keeping program until its primary computer program is functioning smoothly and the costs of its operation are well known. At that point, a proposed operations plan, together with cost to the Association and to the individual physicians, should be presented to the Commission for study.

9. Four resolutions were referred to the Commission by the House of Delegates. Action was taken on each and reported back to the Board as closed with action as follows:

77-26 Voluntary CME for ISMA membership—approved;

77-36 Medical Student Component Society—an Ad Hoc committee of the Commission reviewed subject resolution and presented a new resolution to the Commission. The Commission approved the resolution and has forwarded it to the 1978 House of Delegates. Because current bylaws provide that medical student members may be represented in the House of Delegates with power to vote, the Commission is of the opinion that representation should come through the student body of I.U. School of Medicine. It does not preclude the possibility of forming a section at a later date, but the student body would not derive a vote by virtue of

forming a section. A separate component society should not be formed.

Additionally, it is thought that the student council should be considered the executive body with the power to elect delegates and alternates to the ISMA House of Delegates. Designated methods of student delegate election are incorporated in the new resolution;

77-22 Opposition to Medical School Admission—program defeated;

77-53 Instruction in CPR for Physicians—stemming from this resolution, the Indiana University School of Medicine has altered its curriculum. James C. Dillon, M.D. will head a new segment of curriculum to cover CPR in the first year, with a large segment in the second year and a lesser amount in the third. This will embrace not only CPR, but appropriate segments of emergency medicine. Dr. Beering also asked Dr. Dillon to establish two post-graduate courses in CPR.

STEVEN C. BEERING, M.D.
Chairman

CHARLES HACKMEISTER, M.D.
DAVID A. BYRNE, M.D.
RICHARD RIEHL, M.D.
GARRE E. BLAIR, M.D.
CLEON SCHAUWECKER, M.D.
JAMES R. LEWIS, M.D.
HUNTER SOPER, M.D.
EUGENE GILLUM, M.D.
T. NEAL PETRY, M.D.
NICHOLAS L. POLITE, M.D.
SHOKRI RADPOUR, M.D.
RONALD SCHEERINGA, M.D.
WALLACE S. TIRMAN, M.D.
ERNEST R. BEAVER, M.D.
FRANKLIN A. BRYAN, M.D.
ROBERT CHEVALIER, M.D.
EDWIN S. McCLAIN, M.D.
JOHN ROSCOE
JOHN PHILLIPS, M.D.
GEORGE ALCORN

SUB-COMMISSION ON ACCREDITATION:

EUGENE M. GILLUM, M.D., CHAIRMAN
W. THOMAS SPAIN, M.D.
MICHAEL A. HOGAN, M.D.
DONALD M. SCHLEGEL, M.D.
WILLIAM FECHTMAN, M.D.
RAYMOND PIERCE, JR., M.D.
WILLIAM D. RAGAN, M.D.
JEFFREY KELLAMS, M.D.
CHARLES HELMAN, M.D.
GARRY BOLINGER, M.D.

Reports of Commissions

STEVEN C. BEERING, M.D.
FRANKLIN A. BRYAN, M.D.
SHOKRI RADPOUR, M.D.
RALPH WILMORE, M.D.
KATHERINE RICHARDSON
LARRY HITCHCOCK, M.D.
JOHN PHILLIPS, M.D.
JOHN ROSCOE
JOHN OSBORN, M.D.
JACK W. PEARSON, M.D.
GLEN BINGLE, M.D.
ROBERT E. LONGSHORE, M.D.

Commission on Public Relations

The Commission on Public Relations met in September 1977, February 1978, April 1978 and July 1978.

The Commission concurred that the Tel-Med program was one of the best public relations programs ISMA had ever embarked on, and should not be totally cancelled because of cost considerations. It was, however, discontinued in June 1977. A resolution attempting to justify continuance of the program was defeated by the House of Delegates. Since then, the Tel-Med equipment has been on loan to the St. Joseph County Medical Society, supported by funding from the Northern Indiana Health Systems Agency, Miles Laboratories and others. The program is temporarily being run from St. Joseph Hospital, South Bend.

The idea of placing physicians on the news staffs of TV stations to report on medical news was discussed, and the Commission decided that ISMA should encourage county medical societies to pursue this idea. Staff developed a set of operational guidelines for "physician newscasters," which have been distributed to county societies.

The Commission appointed a committee to investigate the possibility of conducting a seminar to identify health care cost problems. However, since the idea was conceived, ISMA formed a Joint Task Force on Health Care Costs. Efforts of the special four-man committee were halted with the understanding that its data would serve as input for the Task Force.

During Fiscal Year 1977 only four speaking engagements were contracted through the ISMA Speakers' Bureau. Nevertheless, the Commission recommended that the Bureau continue to operate. Letters were sent to county medical societies with brochures from Hopkins Syndicate, which handles the program for ISMA; the letters asked societies to publicize the program.

The Commission proposed holding a review hearing session at each of its meetings in 1978 for constructive input from appropriate outside agencies and individuals regarding any and all areas of medicine and health

care services in Indiana that would relate to ISMA. The proposal, however, was rejected by the Board of Trustees.

In 1977 the Indiana State Board of Health had asked ISMA for comments on its Certificate of Live Birth. The Commission recommended deletion of certain unnecessary questions, but the Board of Health virtually disregarded these comments. The chairman of the Commission queried the Board as to why they ignored ISMA recommendations that race and nationality be eliminated from the form on the basis of the individual's right to privacy. Their response indicated this information was for statistical purposes only and is in no way used to identify specific individuals.

The Indiana Right to Life, Inc. asked for ISMA's opinion on its Informed Consent to Abortion. The Commission noted that changes recommended by the Indiana Hospital Association had been almost entirely ignored by the Right to Life, Inc. ISMA legal counsel stated the present State Board of Health form is adequate and recommended not endorsing the Right to Life form. The Commission sent ISMA's official abortion policy to the group, along with a letter explaining that the present State Board of Health form is acceptable. Right to Life did not respond.

Resolution 77-52, "Instruction in CPR in Accredited Schools," was discussed by the Commission each time it met. Initially, the chairman sent a letter to the Superintendent of the State Department of Public Instruction recommending implementation of CPR into the curriculum of all accredited secondary schools in Indiana. The Department's initial response indicated a possible conflict with special interest groups and a possible infringement on local autonomy in school programming. However, the Commission is continuing its efforts at this time.

Resolution 77-54, "Differential Payment," was considered by the Commission following the Board of Trustees' decision to oppose participating and non-participating clauses in all types of contracts. House Bill 1387, introduced by Robert Hayes of Columbus, would prevent insurers from putting such clauses in their contracts. The Commission tabled discussion of this matter pending further legal opinions and other new information.

Although the Commission felt ISMA should support proposed changes to the AMA's Principles of Medical Ethics (to add clarity to the meaning and modernize the language), the Board of Trustees moved to oppose any changes in the principles as presently written.

The Commission supported a plan by MacDonald's of Central Indiana to give a free hamburger to every child who has completed his immunization program. The plan, requiring only that a child have a signed statement from a physician, was implemented in 27

Reports of Commissions

central Indiana counties.

At the suggestion of the Commission, ISMA purchased a TV receiver and video tape player for use at the headquarters. The equipment allows the recording or playback of TV programs or films through the use of 3/4-inch cassettes. Appropriate recordings can be relayed to county medical societies for viewing at hospitals comparably equipped.

The Commission viewed ISMA's new 10-minute IMPAC public relations slide presentation and recommended it for showing at county and district meetings.

The Commission also viewed the color, 16mm film, "The Buck Starts Here," produced by Blue Cross/Blue Shield. It suggests ways for physicians to help contain the costs of medical care. The Commission agreed it would be beneficial to show to physicians around the state. The Commission approved the purchase of a copy of the film for this purpose.

The Commission heard suggestions from Caldwell-Van Riper, Inc., an Indianapolis advertising/public relations firm, on enhancing the physician's public image in Indiana and satisfying the public's appetite for information concerning the health care field. Although decisions on ISMA's approach to an improved ISMA public relations program have not yet been made, suggestions being considered include production of a 10-minute film and a quarterly newsletter. The film would be used for the ISMA Speakers Bureau, and excerpts of it would be used as TV public service announcements. The newsletter, professionally researched and designed, would be targeted toward news media, HSAs, legislators, labor leaders and Chambers of Commerce. Other public relations approaches also are being explored.

The Commission made its selection for the Journalism Awards and for the Physician Community Service Award. These will be presented at the ISMA's annual meeting in October. Nominations for both categories were submitted by county medical societies.

As chairman of the Commission, I wish to thank the members of the Commission on Public Relations for their participation. The meetings were productive and should help enhance the public relations for the Association.

MARVIN E. PRIDDY, M.D.
Chairman

ALBERT S. RITZ, M.D.
THOMAS O. MIDDLETON, M.D.
ROBERT P. ACHER, M.D.
GREG LARKIN, M.D.
RALPH LEWIS REA, M.D.
ROBERT W. HARGER, M.D.
KENNETH AHLER, M.D.

CHARLES D. EGNATZ, M.D.
HARRY G. BECKER, M.D.
ROSS L. EGGER, M.D.
LOGAN DUNLAP, M.D.
GABRIEL J. ROSENBERG, M.D.
MIKE GOLER—Student member

Commission on Constitution and Bylaws

The Commission on Constitution and Bylaws met once on April 15, 1978. There were no changes in the Constitution, however the Commission approved and recommend the following changes which are both administrative and editorial in nature to the structure of the Bylaws.

For clarification, throughout the printed copy of the Bylaws there are words and phrases in parenthesis and underlined. These are the words and phrases to be deleted. Those words and phrases which are italicized are the words and phrases which are recommended for addition.

The Commission on Constitution and Bylaws may meet one additional time for review of amendment resolutions prior to the 1978 I.S.M.A. Annual Convention.

As Chairman I wish to thank all members of this Commission and the staff for their involvement on this project.

BYLAWS: **DIVISION ONE—MEMBERSHIP** **Chapter I—Qualifications, Election and Rights** **Section 3—Members by Category** **Paragraph H** **Continued**

(Paragraph H. Entire paragraph to be deleted and the following to be inserted.)

H. Inactive Membership. Regular members who decide voluntary inactivity prior to the age of 70 shall be exempt from payment of membership dues for the duration of his inactive status when recommended by the County Medical Society and approved by the Board of Trustees. The inactive member shall receive THE JOURNAL of the Indiana State Medical Association without charge.

DIVISION THREE—BUSINESS AND LEGISLATION **CHAPTER V—House of Delegates** **Section 8—Reference Committees and Committee on Rules and Order of Business.** **Sub-Section C.**

(Sub-Section C. Time and Place of Meetings. Please note the paragraphs in *Italic* are to be added at the end

Reports of Commissions

of the present paragraphs.)

C. Time and Place of Meetings

The time and place of meeting of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

Persons who are not members of the Indiana State Medical Association and seek to appear and present their technical or reference material to the reference committee must receive approval to appear on that specific subject from the reference committee.

Non-Indiana State Medical Association members must register as guests at the committee and be at the call of the reference committee for testimony after which they may be excused from further attendance.

DIVISION THREE—BUSINESS AND LEGISLATION

CHAPTER V—House of Delegates

Section 9—Election of Officers

(Section 9—Election of Officers. 2nd paragraph to be deleted.)

(The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.)

CHAPTER IX—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 8—Duties and Responsibilities

Sub-Section C. The Medical-Legal Review Committee

(Please note the underlined is to be deleted and the words in *italic* are to be inserted.)

C. The (Medical-Legal) *Medico-Legal* Review Committee.

—The (Medical-Legal) *Medico-Legal* Review Committee shall concern . . .

(Proposed Summary to be inserted into the Bylaws.)

D. The Indiana Medical Education Fund Committee. The purpose of this committee shall be to promote, develop and improve medical education in the Indiana University School of Medicine for the general benefit of the entire public by obtaining and using funds from private sources to accomplish that result. The funds collected will be deposited in a trust and at periodic intervals the committee shall make a distribution from the trust to be used by the Indiana University School of Medicine. The Indiana Medical Education Fund Com-

mittee shall consist of eight persons. Five of whom shall be from the Indiana State Medical Association, appointed by the president thereof, all of whom shall be voting members. There shall be three additional members of the committee who shall be exofficio and non-voting and they shall be the Dean of the Indiana University School of Medicine, or his designee, the President of Indiana State Medical Association, and the Executive Director of the Association who shall also act as Secretary of the Committee. The actions of this committee shall be certified to the Executive Committee. Each year a report of the Committee's activities, including a financial accounting report of the fund itself as administered by the trustee, shall be made part of the Executive Committee's annual report to the House of Delegates.

E. The Impaired Physician Peer Review Committee.

—*The Impaired Physician Peer Review Committee shall consist of five members selected from Indiana State Medical Association membership whose duty it shall be to develop a program to recognize, treat and rehabilitate physicians who are impaired by neuropsychiatric illness, physical infirmities or alcohol and other substance dependence. The committee will encourage informal and formal referral of impaired physicians through county medical society screening committees. The committee shall be responsible to develop a program in cooperation with the Indiana Medical Licensing Board using as a guide the Medical Practice Act.*

DIVISION FIVE—MEDICAL DEFENSE

Chapter XV—Medical Defense Administration, Authority and Procedures

Section 1—Dues Allocation

Section 1—Dues Allocation to be completely deleted. (Section 1—Dues Allocation—One dollar and twenty-five cents (\$1.25) out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.)

Section 4—Custodian of funds to be completely deleted.

(Section 4—Custodian of funds—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Board.)

Reports of Commissions

(Section 5—Annual Report. Words underlined to be deleted.)

—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money (received and) expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

(Section 6—Liability. Words underlined to be deleted. Words in *Italic* to be inserted.)

—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal (defense of) *consultation* for its members as may be incurred in accordance with the terms of these Bylaws.

(Section 7—Eligibility. Word underlined to be deleted. Words in *Italic* to be inserted.)

—The Association shall not undertake the (defense) *consultation* of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Director, shall be considered the only bona fide evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense *consultation* against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services, which are the basis of the suit, were rendered.

JOHN B. GUTTMAN, M.D.
Chairman

THOMAS KANDUL, M.D.
RUSSELL DUKES, M.D.
CLAUDE J. MEYER, M.D.
IVAN T. LINDGREN, M.D.
WARREN MACY, M.D.
C. G. CLARKSON, M.D.
GERALD KURLANDER, M.D.
WALLACE A. SCEA, M.D.
JOHN J. SAALWAECHTER, M.D.
FRANK M. STURDEVANT, M.D.

ROBERT M. BROWN, M.D.

WILLIAM R. CLARK, SR., M.D.

LESTER H. HOYT, M.D.

JOHN RECORDS, M.D.

DON CHAMBERLAIN, M.D., Liaison Representative

Commission on Legislation

The Commission on Legislation had two meetings, which were well attended; at one commission meeting there were 26 members present. We were joined by the officers and the Legislative Committee members of the Indiana Academy of Family Practice. The Medical Licensing Board also met with us on certain occasions. We were ably assisted this year by Richard King, legislative analyst and attorney for the Indiana State Medical Association, and Mark Miles, IMPAC representative. The lobbyists on the floor of the Legislature, again, were Fred Garver and Dick Guthrie who have been our legislative lobbyists for the past three years.

The Indiana State Medical Association House of Delegates mandated actions regarding seven areas of legislation in 1977. All of these have been fulfilled by active support or opposition as directed by the House. We were not defeated in our action on any of these six mandated subjects. The House also requested actions on two areas. These were referred to the Board and are mutually being worked out with the Pharmaceutical Association.

The Legislative subjects that required more time of staff, lobbyists, officers of the Association and the Commission were the bills on Certificate of Need, and Generic Substitution of Prescriptions; both were defeated. However, there was a study commission appointed on the subject of Generic Substitution and there have been three meetings this summer by the Joint Study Commission. Your chairman testified on two occasions before that commission and submitted written testimony on another occasion. It is hopeful that this commission will recommend that there be no need in the present prescription law for consumer protection.

An item introduced that was passed and affects all physicians doing pediatrics and/or obstetrics was the bill requiring compulsory hypothyroidism tests on all newborn babies.

At one of our meetings Dr. Kwitny, a member of the Medical Licensing Board and its Executive Director, spoke to us very candidly about the Board's problems on current and pertinent matters. He specifically discussed the matter of the courts giving restraining order to the Board regarding its activity. These matters will affect upcoming legislation, perhaps in the 78-79 Legislature.

Reports of Commissions

During this year the Legislative Commission has monitored federal legislation, especially that regarding National Health Insurance. President Carter had promised that he would have a proposal for National Health Insurance, but it was not introduced until late July, as some 13 guidelines. There is to be no action in the national Congress on this subject this year. Doctor Goodman, Mr. Foy and Doctor Scamahorn, the Commission chairman, visited Capitol Hill at the request of AMA and talked to Representative Sharp of Indiana regarding the cost containment bill proposed by the Carter Administration which undermines and essentially does away with the voluntary effort of the medical profession and the hospitals. We are happy to report that Representative Sharp voted against the Carter proposal and gave a very commendable speech on the floor of the House against this proposal.

On the national Congressional level, IMPAC, directed by Mr. Mark Miles, has planned to have a seminar on national health issues, making contact with key doctors and the Commission relative to the congressional problems.

Your Commission wishes to advise the House of Delegates that it believes the problem areas of the next state legislature will be the Certificate of Need, Generic Substitution, an increase in the scope of chiropractic practice and an increase of practice of the chiropractic profession.

The chairman wishes to thank the members of the Legislation Commission and the staff for their loyal and effective support during this past year.

MALCOLM O. SCAMAHORN, M.D.
Chairman

L. RAY STEWART, M.D.
PAUL J. WENZLER, M.D.
PETER H. LIVINGSTON, M.D.
WILLIAM F. BLAISDELL, M.D.
WILLIAM STRECKER, M.D.
KENNETH WOODMAN, M.D.
MARTIN FUNDENBERGER, M.D.
RICHARD REEDY, M.D.
JOHN KNOTE, M.D.
LEONARD W. NEAL, M.D.
THOMAS R. SCHERSCHEL, M.D.
JERRY L. STUCKY, M.D.
ROBERT M. SWEENEY, M.D.
JOHN G. PANTZER, M.D.
PHILIP N. ESKEW, JR., M.D.
JOSEPH BLACK, M.D.
ERNEST R. BEAVER, M.D.
MRS. ROBERT SCHLEINKOFER, Auxiliary
WILLIAM POND, Student Liaison

Reports of Committees

Future Planning Committee

The Future Planning Committee held two meetings, April 12, 1978 and Aug. 9, 1978, both at association headquarters. Additional meetings were arranged but because of the severe winter, and the chairman's almost psychic ability to choose the days of the worst storms, they could not be held.

Resolution 77-9 (Limitation on Holding Major Offices) was referred to the committee by the House of Delegates for action. The resolution read in part, "That the offices of president, president-elect, speaker, vice-speaker, AMA delegates, AMA alternates delegates, and Board of Trustee members be classified as major offices; and be it further *resolved*, That any individual may not hold more than one major position during a given term and he or she must resign from a major office if they attain a second." After extensive discussion, the Future Planning Committee recommends Resolution 77-9 not be implemented.

Resolution 77-14 (Commission Representation) was referred to the committee for action. The president may appoint one commission member for each 600 active members or major fraction thereof, but in any event, each district shall have one member on each commission. After extensive discussion, the Future Planning Committee recommends adoption of Resolution 77-14.

Resolution 77-49 (Commission Restructuring) was also referred to the committee for action. In part the resolution read: *Resolved*, that a possible redistricting plan be investigated and studied by the Future Planning Committee. After thorough discussion, it was the consensus of this committee that Resolution 77-49 is meritorious; however, it will require much information not available to this committee at present. The Future Planning Committee tabled this resolution until the committee has obtained data with which to work. The committee further requested that five or six plans for redistricting be structured for its study based on such factors as physician population, referral patterns, alignment with congressional districts, etc.

At the request of the ISMA's leadership, the Future Planning Committee agreed to assume the task of compiling a list of goals for the association. These will be studied and evaluated by the committee and circulated to the membership for its reaction.

STANLEY CHERNISH, M.D.
Chairman

PETER R. PETRICH, M.D.
JACK SHANKLIN, M.D.
VINCENT J. SANTARE, M.D.
E. HENRY LAMKIN, M.D.
WALTER HUNTER, M.D. (student)

Grievance Committee

The Grievance Committee has met only once so far this year due to weather problems during the winter and early spring. We anticipate one program meeting before the annual meeting.

Grievances at the time of our meeting in April were similar to those previously noted in prior years—mostly problems relating to communications between the doctor and patient. Seventeen grievances were taken care of during this period of time, and I must commend the physicians of Indiana for their cooperation. We only have one who is not cooperating with this committee.

There have been problems of great depth during this period of time. Most grievances are being handled in a forthright manner.

G. BEACH GATTMAN, M.D.
Chairman

WILLIAM G. BANNON, M.D.
GEORGE T. LUKEMEYER, M.D.
ROBERT E. SNODGRASS, M.D.

Medical Legal Review Committee

The Medical Legal Review Committee had a minimum of internal inquiries submitted to it which were handled by the Chairman with no inquiries requiring committee action.

The Indiana State Medical Association Ad Hoc Committees curtailed activities the Medical Legal Review normally handles, however, the committee chairman strongly endorses the future utilization and continuation of this committee.

The Medical Legal Review Committee will continue to assist the Association in whatever way possible in solving problems affecting the Legal and Medical professions.

JOHN BEELER, M.D.
Chairman

Medical Education Fund Committee

Prompted by a change in executive staff leadership, a thorough review of the Indiana Medical Education Foundation was initiated during the latter part of 1976. In January 1977, Dr. Don Wood, chairman of the Indiana Medical Education Foundation Committee, met with the Executive Committee to discuss the need for reorganization of the Foundation's structure so as to insure more positive administrative control and to avoid any future legal complications. With the assistance of outside legal counsel and the cooperation of the Dean of I.U. School of Medicine, a new resolution amending the original resolution that established the Foundation was drafted and presented for the Executive Committee's consideration during the summer of

Reports of Committees

1977. Essentially, this resolution approved by the Executive Committee:

- 1) Changed the name of the Committee from the Indiana Medical Education Foundation Committee to the Indiana Medical Education Fund;
- 2) Established a new committee structure; and
- 3) Fixed responsibility and reporting.

The amending resolution reads as follows:

Be it resolved, that the committee heretofore known as the Indiana Medical Education Foundation change its name to the Indiana Medical Education Fund;

Be it further resolved, that the committee heretofore structured and known as the Indiana Medical Foundation Committee, or by the shorter title of Foundation Committee, shall hereafter be known as the Indiana Medical Education Fund Committee, or by the shorter title, Medical Education Fund Committee;

Be it further resolved, that hereafter the Medical Education Fund Committee shall consist of eight persons, five of whom shall be from the Indiana State Medical Association, all of whom shall be voting members. There shall also be three additional members of the committee who shall be ex officio and nonvoting and they shall be the Dean of the I.U. Medical School, or his designee; the President of the Indiana State Medical Association; and the Executive Director of the Association who shall also act as Secretary of the committee. A majority of the voting members of this committee shall constitute a quorum for the transaction of business. Applications for funds for medical education and research shall be submitted to the committee by the Dean of the I.U. Medical School accompanied by an explanation as to the specific purposes for which the funds are to be used.

Be it further resolved, that the action of this committee be certified to the Executive Committee and that a full report of this committee's activities as published in THE JOURNAL, including the financial accounting report of the Medical Education Fund itself as administered by American Fletcher National Bank, as trustee, be made a part of its annual report to the House of Delegates.

Be it further resolved, that the President of ISMA shall appoint the five voting members of the IME Fund Committee, including the chairman, for terms of three years to be staggered for continuity purposes.

It is of interest to note that since its inception in 1952, the Foundation (Fund) has disbursed a grand total of \$1,291,462.18 to Indiana University School of Medicine. The present status of the Fund is as follows:

Fund Balance as of 9/30/77: \$354,178.57

Received from AMA-ERF, 3/16/78: \$38,033.86

Fund Balance as of 6/30/78: \$395,832.25

Instructions were given to the trustee (AFNB)

during 1977 to invest the entire Fund in Corporate Bond Fund D (fixed income fund).

DONALD WOOD, M.D.
Chairman

JOE DUKES, M.D.

JACK LOCKHART, M.D.

J. O. RITCHIE, M.D.

JOHN BEELER, M.D.

(Ex Officio) Steven C. Beering, M.D., or his designee; ISMA President; ISMA Executive Director.

Committee on Arbitration and Negotiations

The committee has met three times this year and has advised the following action:

To remove "Arbitration" from the committee's name and function for these reasons: The original intent of the committee was negotiations. Arbitration and Negotiations are antithetical functions. Arbitration functions would usurp functions of other committees. Consequently the committee will notify the Constitution and Bylaws Commission that it feels that "Arbitration" should be removed from the committee name before this committee is inserted into the Constitution and Bylaws.

The committee asked the Board of Trustees to advise longer than one-year tenure on the committee and overlapping of membership. It is felt that this committee needs long term experience without a period of inexperience. This request was referred back to the Commission on Constitution and Bylaws.

The Committee developed its duties as being at least threefold:

To report to the officers, the Board of Trustees, the House of Delegates, and the membership at large actions inimicable to the interest of the ISMA and Indiana Physicians;

To inform other parties of the committee's job of representing the ISMA and Indiana physicians; and

To negotiate specific interests with specific parties upon direction of the officers, the Board of Trustees, and the House of Delegates.

The committee acted upon the following directives from the Board of Trustees and the House of Delegates:

Agreed with the Indiana General Assembly that par-non-par insurance contracts are illegal under existing statutes, notified the Insurance Commissioner of several contracts the committee believes are illegal, assisted the officers in finding specific violations of the above contracts to bring to the attention of the Insurance Commissioner.

Reports of Committees

Discovered that the committee cannot legally (because of "restraint of trade") force insurance companies to semiannually review fee profiles. (Resolution 77 - 32) Alternatively the committee is surveying the ten largest Healthcare insurers in Indiana to determine their policies concerning fee profiles review.

The committee heard reports from ISMA members who attended an advanced Negotiations Seminar in Scotsdale, Arizona.

The Committee is developing a list of "Power Tactics" (a list of social actions which have been used by other groups to accomplish political and social objectives). *Please see attached list.*

The Committee heard Don Crandall, M.D., Chairman of the Department of Negotiations of the Michigan State Medical Society describe the functions of his Negotiations Department. It further asked Doctor Crandall to address the Board of Trustees to which he presented some of the duties and purposes of the Michigan Department of Negotiations. *(Copy of purposes and works attached.)*

The Negotiations Committee is planning to meet one additional time prior to the I.S.M.A. Annual Convention.

I would like to thank members and staff of this committee for all their help and support.

Power Tactics

Strike	Boycott
Withholding of services	Education
Job actions	Negotiations
Paperwork hold-up	Introducing Legislation
Strike fund	Speakers Bureau
Pension fund	Press releases
Elections	Developing candidates
Nominations	Coalition
Public relations (Internal & External)	Non-cooperation
Advertising	Litigation
Lobbying	Writing our own Regulations

PURPOSES AND WORKS OF THE MICHIGAN DEPARTMENT OF NEGOTIATIONS (Crandall, M.D. tape)

- I. Purposes
 - A. Negotiate
 - B. Coordinate—Maintain consistent policies and postures.
 - C. The Health Insurance evaluation committee (sub-committee): Establishing criteria of a good health insurance.
 - D. Screens—Profiles—Payment mechanism.
 - E. Pre-surgical screening program.
 - F. Liaison committees coordinate with the Negotiating Department.
- II. Work of the Michigan State Medical Society Department of Negotiation.
 - A. Original duties
 1. Identification of specific problems amenable to Negotiations.

2. Assembly of all pertinent data and research of problems.
 3. Establishing guidelines.
 4. Negotiation of solution.
 5. Devising of specific action plan.
 6. Coordination of all negotiation activities of the Michigan State Medical Society.
 7. Giving assistance to physicians, medical groups, and communities as requested for negotiating problems.
 8. Education of the membership regarding the use of techniques of negotiations.
 9. At the earliest time possible obtaining authorization from all members of the M.S.M.S. for the Department of Negotiations of the M.S.M.S. be the exclusive bargaining agent for all.
 10. Collect immediately "non-participation proxies" from all physicians to be held in escrow at the M.S.M.S., to be executed in the event of failure at negotiations.
 11. The Department of Negotiation formulate a "Negotiated participation agreement" with third-party payors, which will eliminate for non-participation.
- B. Additional Duties of the Department of Negotiations.
1. Identify research areas.
 2. Monitor data collected.
 3. Monitor all disputes.
 4. Provide liaison with groups in contention.
 5. Consider staff support for above.
 6. Recommend to the council when and where professional arbitrators should be retained.
 7. Recommend to the council the appropriate time for pulling proxies.
 8. Serve as link, with the Medicaid liaison committee; monitor use of plain forms, third party carriers.

ALVIN J. HALEY, M.D.
Chairman

LEONARD NEAL, M.D.
GILBERT WILHELMUS, M.D.
DONALD McCALLUM, M.D.
HERBERT KHALOUF, M.D.
JOHN BEELER, M.D.

Impaired Physician Committee

Since the last annual report, the Impaired Physician Committee met seven times to finalize the program to be used in Indiana.

The first step taken was to request Eli Goodman, M.D., president of ISMA, to name a 13-member advisory committee which would include a representative from each medical district. It was felt that this advisory committee would provide the local contact necessary to implement the program. The recommendation was accepted and a representative has been named from all but district seven and nine.

Next, the Committee agreed that members of the Advisory Committee should serve as the Screening Committee. Each district advisor was asked to set up the examining panel in his district. The examining committee will be a panel of two or three volunteer

Reports of Committees

physicians, both from the committee and around the state, who are willing to evaluate the impaired physician.

It was the opinion of the Impaired Physician Committee that referrals made to this committee, if treatment is not accepted, should be referred back to the original source. However, the committee felt the final decisions on referral should be made by the president of ISMA, thus alleviating any direct pressure on this committee.

A contact roster was then adopted which will include the date, contact number, initials, county referral source, nature of problem, disposition and follow-up. The contact number will include an "I" or "F" for informal or formal contacts. The referral source will indicate only the generic relationship.

Rick King, ISMA staff attorney, recommended the committee change its name to "Impaired Physician Peer Review Committee" to provide greater protection to the committee and the Association. This has been requested of the Commission on Constitution and By-laws.

The committee also sent a letter to the Medical Licensing Board of Indiana commenting on the Medical Practice Act and giving suggestions as to how this committee could work with the Board in handling the impaired physician.

A brochure was written to explain the Indiana Impaired Physician Program and is being distributed at County Medical Society meetings and to all interested individuals to help introduce the program and explain how it will operate. In addition, members of this committee will attempt to attend district or county society meetings to help educate the physicians around the state about the Impaired Physician and the program of rehabilitation that is now available.

Doctors Gerald P. Johnston, Richard W. Campbell, Wallace R. Van Den Bosch, and Thomas E. Lunsford put on a mini-workshop on confrontation techniques for the advisory committee which was very beneficial.

A two-hour general scientific program was approved by the Convention Arrangements Commission for October 23rd. The speakers selected for the program were: LeClair Bissell, M.D., Director of Smithers Hospital, New York, who will speak on the alcoholic physician; E. Richard Dorsey, M.D., Cincinnati, will speak on the drug dependent physician; and Hugh Hendrie, M.D., Indiana University School of Medicine, will speak on the physician with neuropsychiatric disorders.

The Committee also reviewed a letter sent to Governor Otis R. Bowen, M.D., concerning legislation to control amphetamine drugs and one from the American Association of Medical Society Executives

(AAMSE) proposing guidelines for rehabilitation of medical society executives impaired by alcoholism. The Committee's response to the letter to Governor Bowen was, "The Committee recognizes there is over-use and some abuse of amphetamines, however, believes it should be a matter based on the standards of medical practice and not legislation." The committee felt the AAMSE program was sound and recommended that ISMA make a formal endorsement of the guidelines.

Committee members have received many inquiries about assistance for possible Impaired Physicians, and several physicians have been successfully referred for evaluation and treatment.

I want to take this opportunity to express my appreciation to the members of the committee, and those of the Advisory Committee, for their time and effort in this very worthwhile program.

GERALD P. JOHNSTON, M.D.
Chairman

RICHARD W. CAMPBELL, M.D.
THOMAS E. LUNSFORD, M.D.
WALLACE R. VAN DEN BOSCH, M.D.
Advisory Committee
LARRY SIMS, M.D.
DAVID CRANE, M.D.
CESAR ARCHANGEL, M.D.
ROBERT SEIBEL, M.D.
JOHN ELLETT, M.D.
ALFRED HOLLENBERG, M.D.
L. MARSHALL ROCH, M.D.
HARRY HOLWERDA, M.D.
LAURENCE K. MUSSELMAN, M.D.
GEORGE MANNING, JR., M.D.
ROBERT NELSON, M.D.

Sixth Trustee District

CONTINUED FROM PAGE 926

Scamahorn, AMA delegate, was also present and discussed his representation at the upcoming AMA annual meeting.

Officers for the coming year will be Dr. Rhynearson, president; James M. Lorber, vice-president; Douglas Morrell, secretary-treasurer; Dan Hibner, Richmond, alternate trustee.

The Sixth District's 1979 meeting will be held at Rushville with the Rush County Medical Society as host.

D. W. ELLIS
Trustee

Reports of Ad Hoc Committees

Ad Hoc Committee on Improvement of Medical and Health Care in Jails

Inadequate medical care in jails has been a long standing problem for the criminal justice system in this country. Within the past few years, this problem has been the subject of many legal suits. Generally speaking, judges throughout the country have been finding that prisoners have a constitutional right to adequate medical care. In the words of an Arkansas circuit court judge, "If Arkansas is going to operate a penitentiary system, it is going to have to be a system that is countenanced by the Constitution of the United States."

Recognizing the need for national direction with this problem, the American Medical Association applied to the United States Justice Department's Law Enforcement Assistance Administration for a grant to develop health care standards for jails across the country. In 1976, the American Medical Association sub-contracted with the state medical associations in Indiana, Georgia, Maryland, Wisconsin, Michigan and Washington. The project was designed to take three years, with the first year being devoted to development and testing of standards. The second year was designed for implementation and further testing of standards in select pilot jails. The third year was designed for expansion of the project into non-pilot jails.

Since last year, the Indiana State Medical Association has helped design health care delivery systems in the Marion, Greene, and Monroe County jails that have resulted in AMA Accreditation of those jails. The project has already begun to expand to additional jails in Indiana and within the last few months the health care delivery systems at the LaPorte, Allen and Vanderburgh County jails have also been accredited. ISMA staff are currently accepting applications from additional new jails and plan to accredit an additional ten jails during the coming year.

In cooperation with the Indiana Sheriffs' Association, a series of regional seminars was held with sheriffs around the state, discussing the medical/legal implications of jail health care. Jailers from around the state of Indiana recently participated in a four-day jail health care workshop jointly sponsored by the Indiana State Medical Association and the Indiana Sheriffs' Association. The workshop was the first of its kind to be offered in the country and received national publicity.

Under the direction of Dwight Schuster, M.D., Medical Director for the ISMA jail program, the Indiana Jail Project is progressing on schedule. Additionally, Doctor Schuster authored a nationally publicized monograph entitled "The Recognition of Jail Inmates with Mental Illness, Their Special Problems and Needs for Care."

At the present time, it appears that significant progress has been made in improving medical care in county jails throughout the state of Indiana. The project appears to have had a ripple effect into jails that have had no direct contact with ISMA personnel.

During the past year, the project has received favorable attention from the news media throughout the state of Indiana. Most recently, Doctor Schuster and an E.M.T. from the Marion County jail were featured in a Channel 13 (Indianapolis TV) report.

DWIGHT W. SCHUSTER, M.D.
Chairman

MICHAEL J. HUNTLEY
Project Director

Ad Hoc Committee on Computed Tomography

The Ad Hoc Committee on C-T was continued for a second year at the request of the President with the task of monitoring the many issues developing in the field of high cost technology, specifically computed tomography. The Committee is to investigate and make recommendations to ISMA regarding areas they deem require special attention.

Response in opposition to initial Federal Guidelines for C-T was made and resulted in little change by HEW. Cost containment rather than quality care seemed HEW's only concern.

On Dec. 14, 1977, the NIHSA held a public hearing on recommended Criteria and Standards for C-T, to be used as the basis for determining necessity of and requirements for operation of C-T in northern Indiana and perhaps the entire state. Delay was requested and granted on the basis of numerous errors in the document. The members of this committee were apprised of the document and they were asked to provide appropriate suggestions and improvements. The major issues not addressed by this document included (1) the quality of C-T studies, (2) referral, C-T operation and ownership, and utilization review by the same individual, (3) non-approved and mobile scanners and their impact on institutional units. This committee recommended excellent changes to the original document as well as follow-up draft revisions. Many changes resulted in a more understandable and practical set of Criteria and Standards for C-T acquisition.

HEW, through the health planning agencies, will direct their attention to other areas of high cost technology now that the C-T guidelines are developed. This Ad Hoc Committee has completed its intended tasks. It is recommended that ISMA have, on standby, lists of willing and knowledgeable experts in various fields including C-T to be called upon on short notice to respond to important issues as they arise.

Reports of Ad Hoc Committees

The Chairman wishes to commend the committee for their many excellent recommendations and efforts on these matters for the past two years.

DONALD S. CHAMBERLAIN, M.D.
Chairman

L. RAY STEWART, M.D.
ROSCOE MILLER, M.D.
RAYMOND GIZE, M.D.
DAVID GOLDENBERG, M.D.
JOHN JOYNER, M.D.
EVART BECK, M.D.
JAMES L. GRAINGER, M.D.
ROBERT R. NELSON, M.D.
DAVID E. WHEELER, M.D.

Ad Hoc Committee on Immunizations

The Ad Hoc Committee on Immunizations did not meet because there was no action required by this committee.

However, the chairman with the approval of the other members did put together a fact sheet relative to the immunization levels in Indiana as rebuttal to the HEW claims. This fact sheet was then provided to the ISMA Auxiliary as background information in re-writing the AMA promotional material on immunizations to reflect the Indiana picture. In addition, the fact sheet was used as the basis for another press release titled, "Continuing Immunization Program Not Necessary," and was also provided to the Indiana Academy of Pediatrics and the Indiana State Board of Health Immunization Action Committee and the Indiana Academy of Family Physicians.

The chairman believes the need for this Ad Hoc Committee is still viable and would hope that it is kept intact.

ROBERT L. PARR, M.D.
Chairman

IVAN LINDGREN, M.D.
RONALD RHODES, M.D.
LAMBRO DIMITROFF, M.D.
ROBERT SEIBEL, M.D.

Ad Hoc Data Processing Steering Committee

In order to oversee the development of ISMA's computer capability, your Association's President, Dr. Eli Goodman, appointed an ad hoc Data Processing Steering Committee and requested me to serve as Chairman. The Committee has had four meetings and will meet once more before the ISMA annual convention.

At its initial meeting, the Committee reviewed its charge and agreed that its responsibilities included:

1. Overseeing and approving the design of ISMA's new membership system;
2. Approving any additional computer applications made possible as a result of an expanded capability;
3. Approving all systems logic and procedures to be used in data collection;
4. Establishing and approving all policies governing the collection, storage, retrieval and release of data; and
5. Studying the feasibility of establishing a medical data center to monitor the quality of care delivered in ambulatory settings.

Initially, the Committee was provided with an update on the various computer application projects with which ISMA is involved.

The proposal to the Medical Licensing Board of Indiana to automate its records and procedures will probably not be implemented this year due to a lack of funding on the part of the Medical Licensing Board. There was no provision made in the Bowen Administration's budget this year for such services. Moreover, the Administration will encounter difficulty in justifying computerization for just the one Board (Medical Licensing Board).

The Committee discussed at length the data items presented by ISMA staff to be components of the ISMA physician data base. Accordingly, the Committee approved for incorporation into the new ISMA data base those data items presently part of the AM-CAP file as well as those data items that are presently part of the AMA file or part of existing ISMA records. The Committee agreed that further determination be made as to what items should be added to the data base in logical segments so as to avoid excessive computer programming. County medical society executives were also given an opportunity to suggest items to be included in the ISMA system that might be unique to their society's data requirements. In this connection, the Committee also approved the newly designed billing form for the ISMA computerized membership system contingent upon further discussion with AMA staff to insure compatibility with the criteria established for the AMA's 1979 direct billing program.

The issue of ISMA's involvement in facilitating the data processing applications of Indiana's PSROs was considered by the Committee. The Committee approved the principle of ISMA's involvement in meeting the data processing requirements of the various Indiana PSROs. The Committee felt that such an active role on the part of ISMA does not appear to be in conflict with ISMA's policy on PSRO as it would enable ISMA to better protect the confidentiality and release of phy-

Reports of Ad Hoc Committees

sician-generated data in addition to providing ISMA with the capability of refuting and validating government reports.

The Committee discussed the concept of forming an ISMA Foundation for Medical Care in order to accommodate all future ISMA computer applications. Staff made contact with state medical societies in Colorado, Texas, and Georgia—all of whom have active medical care foundations. It was pointed out, however, that there may be some difficulty at the present time in obtaining an IRS foundation classification (501 C-3) since the entire matter is currently being studied by government. The Committee was reminded that I-MEDIC had been established several years ago [as a ISMA not-for-profit corporation] for the express purpose of providing a mechanism for ISMA involvement in PSRO data collection and processing and other computer applications. Although I-MEDIC has been incorporated as a not-for-profit corporation, ISMA never applied for an IRS classification determination. It was suggested that perhaps I-MEDIC could be activated to function as a contracting party with outside groups, such as PSROs, and that I-MEDIC in turn could purchase its required data processing services from ISMA. As a result, ISMA legal counsel was requested to research the status and potential use of I-MEDIC as a mechanism for accommodating future ISMA computer applications.

Following discussions between ISMA legal counsel and representatives of the George S. Olive Company, it was recommended that I-MEDIC, if to be used at all, be converted to a for-profit corporation. The IRS has recently been according close scrutiny to non-profit associations establishing not-for-profit corporate entities to accommodate unrelated activities. It was further recommended that ISMA own all of the stock in I-MEDIC in order to ensure control of its activities. As a result, I-MEDIC was recently converted to a for-profit corporation.

Contracts were executed with the Board of Health which provided for the collection of information and submission of summary reports by ISMA on the availability and delivery of certain specialized health services such as: diagnostic radiation, therapeutic radiation, cardiac care, outpatient services, emergency services, and computed tomography. The methodology for collecting the information consisted of mailed questionnaires and personal visitations to some of the largest hospitals in the state. This was done with the knowledge of the Indiana Hospital Association but without its official participation. Results of the survey have been most gratifying, with responses received from approximately 80% of the 126 hospitals included in the study.

The Committee expended considerable time and ef-

fort in studying and investigating the AUTOGRP computer system for possible use by I-MEDIC in satisfying the data processing needs of Indiana PSROs, should I-MEDIC be selected as a data processor. The AUTOGRP system is an interactive computer system developed at Yale University under a grant from HEW to enhance the capabilities of PSROs in the areas of quality assurance and utilization review. Since ISMA's present computer system does not have the technical capability to meet PSRO data requirements, the Committee endorsed I-MEDIC's use of the AUTOGRP system in developing proposals for data processing services to PSROs. Responses to Requests for Proposals (RFPs) have been submitted by I-MEDIC to Area V PSRO and responses are presently under preparation for several other PSROs that recently achieved conditional status.

JAMES GOSMAN, M.D.
Chairman

ALVIN J. HALEY, M.D.
ARVINE POPPLEWELL, M.D.
STANLEY CHERNISH, M.D.
PETER R. PETRICH, M.D.
THOMAS A. GEHRING, M.D.
H. MARSHALL TRUSLER, M.D.

Resolution No. 78-14

Introduced by: Vanderburgh County Medical Society

Subject: CONTINUOUS CARE IN HEALTH CARE FACILITIES

CONTINUED FROM PAGE 932

only limited periods each day, forcing the patient to seek alternative sources for care when urgently needed outside regular hours, is receiving less than quality medical care; now, therefore be it

Resolved, That any health care facility which does not provide for continuous care available 24 hours a day, seven days a week, should not be considered entitled to licensure by any governmental agency or reimbursement by third-party agencies; and be it further

Resolved, That the Indiana State Medical Association seek to influence legislation and governmental regulations in order to ensure the availability of round-the-clock medical care by such health care facilities.

Reports of Trustees

First Trustee District

The annual meeting of the First District Medical Society was held at Evansville Country Club on Thursday, May 18, 1978, and 153 doctors and their wives turned out for the occasion. Many guests were in attendance, including the following representatives of the Indiana State Medical Association: Dr. & Mrs. Eli Goodman, Dr. James Harshman, Dr. Lloyd Hill, Dr. Martin O'Neill, Dr. Arvine Popplewell, Mr. Don Foy, Mr. Ron Dyer, Mr. Mike Huntley, and Mr. Mark Miles. Mr. Jerry Martin was present representing Indiana Blue Shield, and Dr. Bernard Rosenblatt introduced his son, Dr. Randall Rosenblatt.

Lively entertainment was provided during the cocktail hour by Vintage Red, a Dixieland jazz band from Bloomington, which brought the crowd to its feet with their rousing Dixieland rendition of the Indiana University fight song.

Dr. James Marvel, First District president, announced that ISMA field man, Bob Amick, would soon retire, and thanked Bob for his 26 years of service to the physicians of southern Indiana. Dr. Tom Clark, chairman, presented trophies to the winners of the 1978 Bob Acre Memorial golf tournament. They were Dr. Jim Heinrich, who took low net with a gross of 77 and a net of 72, and Dr. Dennis Hodge, who won low gross with a round of 76.

Those present were most interested in the report of Dr. Ralph Carlson, Indiana Blue Shield Trustee from the First District. Dr. Carlson reported that Blue Shield was under attack by three different governmental entities: the Federal Trade Commission, the Indiana Insurance Commission, and the Moss Subcommittee of the United States Congress. He detailed charges made by the Insurance Commissioner and concluded with the observation that he could not predict how these difficulties would be resolved.

Dr. Albert Ritz, First District representative on the ISMA Commission on Public Relations, urged those present to work harder at getting the facts about health care costs before the public. To this end, he recommended use of the ISMA bureau of non-physician public speakers.

A report on the American Medical Association was presented by Dr. Patrick Corcoran, AMA Delegate, who emphasized that AMA is moving vigorously against federal regulatory agencies which seek to infringe upon the practice of medicine. Dr. Corcoran noted that AMA is currently investing \$50,000 a month in the defense against FTC, alone.

Dr. Fred Smith, District IMPAC representative, introduced the IMPAC staff liaison with ISMA, Mr. Mark Miles, and everyone enjoyed the excellent audio-visual show he subsequently presented. Other business

included a request from Dr. Gilbert Wilhelmus for support of Dr. Joe Black's candidacy for re-election to the Indiana University Board of Trustees. New First District officers elected at the meeting are Dr. Forrest Radcliff, president, Dr. Frank Hilton, vice-president, and Dr. William Wells, secretary-treasurer. The date chosen for the annual meeting in 1979 is Thursday, May 17.

Last year the First District sponsored a caucus and hospitality room at the state convention for the first time, and it worked so well that our delegation has decided to follow the same procedure in Clarksville this fall.

I am deeply indebted to the officers and ISMA commission members from the First District who worked hard all year to represent us at the state level, and I am especially grateful to Dr. DeVerre Gourieux, my alternate, who so graciously filled in for me at those meetings of the Board of Trustees which I was unable to attend.

JOHN BIZAL, M.D.
Trustee

Second Trustee District

For the past year we have remained rather dormant, quietly going about our business and with little accomplished with little to stimulate our association.

Apparently there is little threat, at present, regarding government imposition on health care delivery. One must assume that the present administration in Washington is good for medicine. They are either too broke or too divided in their opinions to be a real threat to our fraternity.

I can envision in the coming months some good fights and stimuli arising from (1) our relationship with the Blues and (2) our concern with the ever-menacing HSAs and PSROs. This is my swan song—my best to all.

PAUL W. HOLTZMAN, M.D.
Trustee

Third Trustee District

Of interest during this past year to the members of the Third District Medical Society was the action taken on Resolution 77-2 entitled "OPPOSITION TO NATIONAL HEALTH INSURANCE."

Introduced by the Clark County Medical Society in the 1977 House of Delegates, the resolution requested the ISMA Board of Trustees to poll all ISMA members as to whether or not they want the AMA to withdraw their bill for comprehensive health insurance and vigorously oppose any AMA comprehensive health insurance bill.

Reports of Trustees

The resolution further asked that the ISMA ask all other state associations to do the same with their memberships and that, if those polls reveal that the majority of physicians are of like mind, then prepare and submit a resolution to the AMA instructing the AMA to follow the dictates of its membership.

The poll was taken by the ISMA and on the first question—"Should the AMA withdraw its bill for comprehensive health insurance?"—337 answered YES and 341 registered a NO vote.

On the question "Should ISMA oppose any form of AMA comprehensive health insurance bill?" 300 reported YES and 371 said NO.

The total vote on the questions comprised 15½ % of ISMA dues-paying members.

Results returned from other state medical associations included North Carolina, Colorado, and California, which voted with the majority of Indiana votes, i.e., NO and Kansas voted YES.

As usual I have attended most of the Board of Trustees' meetings and will continue to do so, keeping the District's views in mind.

THOMAS A. NEATHAMER, M.D.
Trustee

Fourth Trustee District

The Fourth District had its annual meeting at Madison, Ind., May 24, 1978. At the afternoon meeting Dr. Jack Hague spoke on "New Approaches to the Treatment of Arthritic Pain." The presentation was well received. At our business meeting in the afternoon, Dr. Alvin Henry of Columbus was re-elected Blue Shield representative, Dr. Brockton Weisenberger of Columbus was elected president of the Fourth Medical District, Dr. Mark Bevers of Seymour was elected vice-president and Dr. William Cooper of Columbus was elected secretary-treasurer. At the evening meeting Dr. William Salter of Adelaide, Australia spoke on "Medical Delivery System in Australia." This was a very informative and enjoyable speech and again was well received by all present.

The Fourth District wishes to thank the officers and other trustees and the staff of ISMA for attending the district meeting. The Fourth District medical meeting in 1979 will be held in Columbus, Ind. at a date to be determined.

HOWARD C. JACKSON, M.D.
Trustee

Fifth Trustee District

With the annual meeting of the ISMA in October comes the termination of my second term as trustee of the District. I will have served five years as alternate trustee, and six years as trustee. That seems like an aw-

fully long time, but in all sincerity, I consider it one of my finest learning experiences.

First, I hadn't previously realized the extremely high quality of the people who serve the membership as trustees, delegates, members of the various commissions, AMA representatives, etc. Secondly, I learned just how democratic the AMA really is. Each county picks its delegate(s), and he/they choose the representatives to the AMA. It could not be more democratic than that. I have heard much criticism of the AMA as you have, but I can assure you, the delegates from Indiana were 100% representative of those who elected them. The trustees received copies of their voting record, and it is certainly something to be proud of. Of course, in this area of the U.S., we have a conservative viewpoint, and that is the way our delegates voted. Unfortunately, there are just more doctors in some of those areas of the country who do not have such conservative viewpoints.

The number of delegates to the AMA is based on the number of physicians of the individual state, and some of the states with the more liberal viewpoint just happen to be more heavily populated, and hence have more physicians, and hence more delegates to the AMA. As a result, the conservative viewpoint was outvoted; but our delegates cannot be blamed for this. There are those who maintain that the world is changing and the conservative outlook is no longer correct; I happen not to agree. I am firmly convinced this trend toward socialism and bigger and bigger government is not the right road; unfortunately, at the present time, I belong to a minority viewpoint on this subject, not only among doctors across the country, but the people who elect our government officials also seem to have convinced the majority of citizens that socialism is the wave of the future.

But, I still don't think we should abandon the AMA and join some other organization that happens to be more vocal at this moment; we have a very democratic organization and I think the proper course for those of us who believe as I is to work even harder to increase the membership in this organization, make it even more powerful and try to convert some of our fellow physicians to our way of thinking. Always remember the basic fundamentals that made our profession the great profession that it is, and those same fundamentals that made this country the great country that it is—these did not originate in Washington; they originated from the people.

The Fifth District meeting was held at the Allendale Country Club in Terre Haute, Wednesday, May 3, 1978. Dr. Franklin Swaim presided. The scientific session was put on by the Indiana Academy of Family Physicians—an excellent program. The business meeting started at 4 p.m. We had an excellent representa-

Reports of Trustees

tion of the "official family" including Dr. Martin O'Neill, chairman of the Board; Dr. Eli Goodman, president of the ISMA; Dr. James Harshman, president-elect; Dr. Arvine Popplewell, treasurer of the ISMA. Also present were the following staff members of the ISMA: Don Foy, executive director; Mike Huntley, field representative; Bob Amick, field representative who retired this year, and who did a very outstanding job these many years; Ron Dyer, staff attorney; and Rosanna Iler, membership activities.

The following officers were elected:

Dr. Paul Siebenmorgan, trustee of the Fifth District;

Dr. Jauw B. Kho, M.D., Terre Haute, president of the Fifth District;

Dr. Clyde W. Jett, re-elected secretary-treasurer.

The next meeting will be at Terre Haute May 9, 1979.

Following the dinner, attended by approximately 90 persons, Doctor Bowen gave an excellent talk.

Again my thanks to each and every one of you for allowing me to be your Trustee, and my best wishes go to Dr. Paul Siebenmorgan, your new Trustee.

CLEON M. SCHAUWECKER, M.D.
Trustee

Seventh Trustee District

The Seventh District Medical Society's 1978 meeting was held June 14 at the Valle Vista Golf Resort. The well-attended meeting was chaired by Seventh District President, Dr. William C. Stafford.

Following acceptance of the Secretary/Treasurer's reports, an opportunity for brief comments was provided to Dr. Eli Goodman, President, Indiana State Medical Association, and to Dr. James A. Harshman, President-Elect, Indiana State Medical Association. Also introduced were Dr. Lloyd L. Hill, Speaker, ISMA House of Delegates; Dr. Martin J. O'Neill, Chairman, ISMA Board of Trustees; Dr. Arvine G. Popplewell, Treasurer, ISMA; Dr. Joseph F. Ferrara, Assistant Treasurer, ISMA; and Mr. Don Foy, Executive Director, ISMA. Mr. Foy introduced the ISMA staff in attendance.

A break in the routine agenda items provided the opportunity for the presentation of a plaque to Mr. Robert J. Amick on the occasion of his anticipated retirement as ISMA Field Representative. The plaque read "Presented to Robert J. Amick from the Seventh District Medical Society in recognition of his dedication and service to the physicians of Hendricks, Johnson, Marion and Morgan Counties, presented this fourteenth day of June, 1978." In his comments, Mr. Amick took the opportunity to encourage the members to stick together, especially politically.

Elections were then held for the Seventh District of-

ficers and resulted in the selection of Dr. M. Max Wesemann to succeed Dr. Stephen L. Hardin as President-Elect, and Dr. Malcolm O. Scamahorn to succeed himself as Secretary/Treasurer. Also elected to succeed himself was Dr. John G. Pantzer for a three-year term as Seventh District Trustee.

Following the business meeting, the district members adjourned to join their guests for cocktails and dinner, followed by a presentation by Professor Henrich.

DONALD C. MC CALLUM, M.D.
JOHN G. PANTZER, M.D.

Trustees

Eighth Trustee District

Since a review of transactions of the ISMA Board of Trustees is available elsewhere, this communication to the membership of the Eighth District will not undertake such a report. Also a chronicle of the activity of your trustee at Board meetings would be unwieldy. Let me summarize in this way:

Members of the Eight District Medical Society, comprising the medical societies of Jay County, Randolph County, Madison County and Delaware-Blackford County, are generally conservatively disposed philosophically, and it has been my effort to represent the district and its views at the ISMA Board of Trustees. Sometimes such views prevail and sometimes they do not, but they are always presented.

The subjects of overriding importance to physicians in the Eighth District are those concerning deterioration of good medical practice due to federal government intervention. Thus the implementation of PSRO, establishment of HSA regulations, national health insurance, and a host of proposed federal laws and regulations are regularly opposed. Also our representatives at the AMA are urged to maintain a conservative posture. Support is given to all Board proposals and AMA activities that foster better standards of medical practice, protect medical and economic freedoms of physicians and patients, and promote high standards of medical practice.

The members of the Eighth District Medical Society enjoyed meeting together June 7, 1978 at the Green Hills Country Club in Delaware County. The meeting was hosted by Randolph County Medical Society, and Dr. Lowell Painter served as president, with Dr. H. W. Koch as secretary. Paul Page, The Voice of the 500, entertained at the dinner meeting. Officers for 1979 for the Eighth District were elected and the Jay County Medical Society was selected as the host for the 1979 meeting.

JACK M. WALKER, M.D.
Trustee

Reports of Trustees

Ninth Trustee District

The 1978 Ninth District meeting was held in Lafayette, hosted by Hamilton County. Dr. Earl Butz, former U.S. Secretary of Agriculture, was the speaker. His topic was, "Good Government is *Your Business*." The dinner and presentation were well attended, but only 14 Ninth District members attended the business meeting (only seven of these were not elected officers or involved in planning the meeting).

The 1979 meeting will be hosted by Tippecanoe. I urge all Ninth District members to re-examine their schedules to determine if they can devote slightly more time to involvement to non-medical aspects of medical practice. Please plan to attend the 1979 meeting.

I visited approximately one-third of the county societies this year, and I received some good input at each meeting. The main concerns of the members with whom I spoke seemed to center around the increase of government involvement in medicine and the relationship of ISMA to the third-party carrier. There is even some hint that members are questioning whether the third-party carriers are more interested in their relationship with the government and industry than they are in serving their individual clients (the patients).

At any rate, the ISMA Board of Trustees has spent much of its time this year discussing the problems of government involvement and our relationship with third-party carriers. Please give us your formal and/or informal input on these, or any other, matters that are problems in each of your areas.

I am very pleased to be the Ninth District Trustee, and once again thank you for this opportunity. Please assist the ISMA Board of Trustees by attempting to allot more time for involvement in the non-medical matters that affect medical practice.

JOHN A. KNOTE, M.D.
Trustee

Tenth Trustee District

The Tenth Medical Trustee District consists of Lake and Porter counties, in northwest Indiana, and contains approximately 600 ISMA members. Both counties are actively seeking the membership of physicians practicing in the area who are not presently affiliated with their County and State Medical Associations. This is being done by citing the benefits of membership. AMA membership is highly recommended.

The last annual meeting of the District was held May 31, 1978 at Lake of the Four Seasons, near Valparaiso. District President, Dr. James Brown, Valparaiso, con-

ducted the meeting. The minutes of the October 1977 meeting were read and approved. At that meeting Dr. Martin J. O'Neill, Valparaiso, was re-elected Trustee. Dr. O'Neill, also Chairman of the ISMA Board of Trustees, made the annual Trustees report. He said that at the AMA annual meeting in St. Louis, in June 1978, some principal items on the agenda would be revisions in the AMA Principles of Medical Ethics, cost containment, and the payment for second surgical opinions by insurance carriers. All these issues have been discussed at ISMA Board meetings and the ISMA Delegates to AMA are aware of the Board's feelings. He said the State Association, along with the Indiana State Hospital Association, has developed a statewide commission to study health care costs. There are representatives of labor, industry, insurance, and government on this commission.

Dr. O'Neill appealed for increased physician input and participation in the Health Systems Agency organizations. He announced that the ISMA poll on the AMA's National Health Insurance Plan showed the Indiana physicians are in favor of AMA's involvement, but about evenly divided on the present AMA plan. Dr. O'Neill said that one of the principal subjects currently being studied by the ISMA Board is the Association's participation on the Blue Shield Board of Directors, and said that this subject will also be an important item in the House of Delegates meeting in October. He discussed the recent visit of ISMA officials to Washington, and said the reception given by the Indiana Congressmen, Senator Lugar, and Senator Bayh's staff was the warmest ISMA ever received.

Dr. Brown introduced the following guests:

Dr. Eli Goodman, ISMA President;
Dr. James Harshman, ISMA President Elect;
Dr. Lowell Steen, AMA Trustee;
Dr. Leonard Neal, Alternate-Trustee tenth District;
Dr. Arvine Popplewell, ISMA Treasurer;
Dr. Lloyd Hill, ISMA Speaker of the House of Delegates;

Dr. Larry Allen, Vice-Speaker of the House;
Dr. Peter Petrich, AMA Delegate;
Dr. Thomas Tyrrell, Alternate AMA Delegate;
Dr. Vincent Santare, ISMA Past President;
Dr. Wm. Fitzpatrick, District Blue Shield Representative;

Dr. Thomas Gehring, Lake County Med. Soc. Pres;
Dr. Lee Trachtenberg, President, Calumet area foundation for Med. care;

Mr. Don Foy, ISMA Executive Director;
Dr. Howard Grindstaff, ISMA Field Representative;
Mrs. Rosanna Iler, ISMA Membership Coordinator;
Mr. Herb Dixon, Vice-Pres., Blue Shield;
Mr. Mark Miles, IMPAC Representative.

Reports of Trustees

Each of the guests made short but pertinent comments and answered questions.

Dr. Brown then declared the District elections in order. The following were elected to office:

President, Dr. Lee Trachtenberg;

Secretary, Dr. Barron Palmer;

District Representative to Indiana Blue Shield, Dr. Wm. Fitzpatrick.

The meeting then adjourned and reconvened at 7 p.m. for dinner.

Prior to dinner, Dr. Eli Goodman announced the death of former ISMA Executive Secretary, James Waggener, who served in that office from 1949 to 1975. A moment of silence was observed in memory of Mr. Waggener.

During dinner, a Panasonic TV set was donated by Mr. Don Laser of Laser Pharmaceuticals Company, and it was later presented to Dr. Joseph Kopcha. Golf prizes were awarded as follows:

Closest to the pin on the 17th hole, Mrs. Mary Lou Evans;

Ladies Trophy, Mrs. Paul Alvarez;

Low net trophy, Dr. Ora Marks;

Low gross trophy, Dr. E. J. DeFrazia.

Following dinner, Dr. Brown introduced Mr. Lee Corso, head football coach of Indiana University, who delivered a rousing and hilarious talk regarding his experiences as coach at I.U. and discussed the philosophies he considers important in addition to simply winning games.

A ladies program in the afternoon featured Alexandria East, a TV personality whose subject was "Dreams—the Magic Mirror of Your Mind."

Because of my activities as Chairman of the Board of Trustees of ISMA, I haven't been able to attend as many of the LCMS meetings as I would like, but under the expert guidance of Executive Secretary John Twyman, President Dr. Thomas Gehring has been doing an excellent job. In Porter County, Dr. James Brown has been playing the dual role of PCMS President, and also President of the Tenth District and doing a very commendable job. At the last executive committee meeting, the Porter County Medical Society Charitable Trust was renamed The J. William McBride Charitable Trust in memory of Dr. McBride, one of the original Trustees, who died recently at the age of 40 years.

The Calumet Area Foundation for Medical Care has grown under the presidency of Dr. Lee Trachtenberg with the assistance of Mr. Charles Shoemaker, Executive Director, and his staff. CAPRO (Area I-PSRO) has a membership of 495 physicians in the three-county area of LaPorte, Lake, and Porter. This represents 56% of eligible physicians in this area. Dr. Frank Sturdevant, Valparaiso, is president of CAPRO and

Dr. Vincent Santare is Chairman of the Board of Directors. The Executive Director duties are shared by Mr. Shoemaker with Mr. John Ling.

Again, I would like to thank all the ISMA officers and staff, and AMA Trustee, Dr. Lowell Steen, for their participation in the Annual Meeting.

MARTIN J. O'NEILL, M.D.
Trustee

Eleventh Trustee District

The Eleventh District Medical Society will meet Wednesday, Sept. 20, 1978. The meeting will be held at the Rolling Green Golf and Supper Club in Peru. Miami County will be the host society. They are working very hard on the program in an effort to revitalize our district meeting. Digger Phelps will be the after-dinner speaker. In addition to the business meeting, the program includes golf, tennis and an extensive program for the ladies.

Last September's meeting was hosted by the Wabash County Society at the Peru Country Club. Among the guests at the meeting were Dr. Eli Goodman, Dr. John Beeler, Dr. Vincent Santare, Dr. Martin J. O'Neill, Mr. Donald Foy and Mr. Howard Grindstaff.

The business meeting was conducted by Dr. William Dannacher, district president. Dr. Amando Baluyut was elected president of the district society and Dr. Fred Poehler was reelected secretary. Dr. Herbert Khalouf was elected alternate trustee. The members of the society expressed their desire that the secretary of the district society should fill the alternate trustee position should it become vacant.

The Eleventh District is proud that our trustee, Dr. James Harshman, has become president-elect of ISMA. Dr. Khalouf has been filling the remaining term as trustee and Dr. Poehler has been filling the office of alternate trustee.

I wish to thank the members of the Eleventh District for the privilege of representing our district on the ISMA Board of Trustees.

HERBERT C. KHALOUF, M.D.
Trustee

Twelfth Trustee District

The Twelfth District officers met three times this year and will meet at least once more. Business includes Twelfth District problems, planning the Annual District Meeting (to be held Thursday, Sept. 7, 1978, at the Imperial House Motel, Fort Wayne) and planning for the annual ISMA meeting. Several resolutions for the ISMA meeting are under consideration.

One of my trustee duties this year has been serving on the Blue Shield Liaison Committee of the ISMA.

Reports of Trustees

Here I have observed the physician representation on the Blue Shield Board come under the attack of both our state and federal governments, who are convinced this representation is in restraint of trade. They also are convinced that physicians serving on Blue Shield Board of Directors encourage ever-increasing payments to physicians.

I wonder. It seems to me that the Blue Shield, with its physician directors, has been extremely competitive toward other insurance companies; insureds have benefited from this competition! Giving this observation still another twist, perhaps other insurance companies would benefit (and their customers) with physician directors! Relations between Blue Shield and ISMA have been strained over various issues in the past, but—at least at the present—both boards wish to keep the physician representation.

I personally hope this representation can be maintained in a high level of cordiality; an adversary relationship—whether forced by governmental actions or caused by disagreements—would be time-consuming, costly, and tragic to both organizations.

Another duty (and privilege) this year has been the chairmanship of the Negotiations Committee; please read its report elsewhere in this section.

Of course, the most important duty and honored privilege (now for four years) has been representing you, the Twelfth District physicians at the ISMA Board of Trustees.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District

The Thirteenth District Medical Society annual meeting will be held at South Bend's new Century Center Complex Sept. 13, 1978. Dr. David Spalding, President, has an exciting program scheduled; a seminar on negotiations will be followed by a business meeting, dinner and entertainment. Election for the very important position of District Representative to the Blue Shield board will occur. Dr. Francis Kubick has ably fulfilled two terms. A difficult job well done!

The previous annual meeting was not reported in the Trustees official report due to a change in the format, but it was a great success. Dr. Elmer Billings and retiring super-trustee, Dr. Beach Gattman, put on quite a show at Elcona Country Club. The business meeting featured the usual row of distinguished guests including AMA trustee, Dr. Lowell Steen, and ISMA presidents, Dr. Ken Olson (1960), Dr. Vincent Santare (1976), Dr. John Beeler (1977), Dr. Eli Goodman (1978) and president-elect Dr. James Harshman. Mr. Don Foy, executive director of ISMA, and many of his staff were present. Dr. David Spalding was elected presi-

dent, Dr. William Staffk, president-elect, and Dr. Michael Quinn, secretary-treasurer. Dr. Donald Chamberlain was elected trustee to replace Dr. Gattman, who had completed the maximum allotted two terms. Dr. Gattman's distinguished service and representation for our district for the past 12 years was appreciated and recognized by a plaque given by our members. Dr. John Luce was elected Alternate Trustee to a two-year partial term originally held by Dr. Chamberlain.

Many issues were discussed, including the impact of government regulations on our practices. The district voted to reevaluate the alignment of the medical districts so that they would better conform to HSA and PSRO areas. The medical profession would thus be in a position to monitor and respond to the many issues developed by these agencies. This suggestion is presently being considered by the ISMA.

As your new Trustee, I would like to thank the members for permitting me this honored position. In order to fulfill my responsibilities as Trustee, I need to know and understand your desires and wishes so that you may be adequately represented on a State level. Please feel free to call upon John Luce or myself regarding any problems or questions you may have in your practice. We will do our best to serve you.

DONALD S. CHAMBERLAIN, M.D.
Trustee

Sixth Trustee District

The Sixth District sustained a significant loss in dedicated leadership earlier this year with the death of trustee Glen Ward Lee. Dr. Lee was beginning the second year of his three-year term when he died suddenly while on vacation in Florida. He had served as alternate trustee when Paul Inlow was trustee during the previous three years. I recall Dr. Inlow's remarks about Dr. Lee in reference to his sincere attention to ISMA Board of Trustee business even as an alternate.

Since Dr. Lee's death, I have attempted to fill his shoes, having been appointed by the Board of Trustees to serve his unexpired term. I contacted each county medical society president by letter in July. I intend to keep in touch with them concerning local feelings on important ISMA considerations. It is also my intention to carry out the personal visitation requirement.

In May the Shelby County Medical Society hosted the Sixth District Medical Society's annual meeting. All county medical societies within the district were represented at the afternoon business session. Dr. Hal Rhyne-earson, president of the Sixth District, presided. The ISMA staff and Executive Committee were present and contributed to the business discussion. Dr. Malcolm

CONTINUED ON PAGE 917

County Medical Society Directory

County	President	Secretary
Adams	John E. Doan, Decatur	Hyung Soo T. Lee, 227 S. Second St., Decatur 46733
Allen (Fort Wayne)	Jerald L. Andrew, Fort Wayne	Robert W. Dettmer, 2828 Fairfield Ave., Fort Wayne 46806
Bartholomew-Brown	Robert G. Reed, Columbus	Mr. Larry L. Pickering, Exec. Dir., 212 Med. Ctr. Bldg., Fort Wayne
Benton	A. L. Coddens, Earl Park	Stanley R. Adkins, 380 Plaza Drive #D, Columbus 47201
Boone	Donald Boyer, Lebanon	Manley K. Scheurich, R.R. 1, Oxford 47971
Carroll	Stephen C. Mayers, Flora	John J. Saalwaechter, 404 W. Camp St., Lebanon 46052
Cass	Joseph Howard, Logansport	Robert Seese, 101 W. North St., Delphi
Clark	Joselito Millan, Jeffersonville	Carl R. Boyd, 2 Chase Park, Logansport 46947
Clay	Robert C. Oehler, Brazil	Jerrold E. Tomlin, 1220 Spring St., Jeffersonville 47130
Clinton	Milton Erdel, Frankfort	E. L. Conrad, 1207 E. National Ave., Brazil
Daviess-Martin	Marshall Seat, Washington	William R. Stapleton, 1256 S. Jackson, Frankfort 46041
Dearborn-Ohio	Henry Conrad, Lawrenceburg	James P. Beck, 1312 Bedford Rd., Washington 47501
Decatur	Gene P. Gebele, Greensburg	Gerald T. Bowen, 705 Tanner Ave., Lawrenceburg 47025
DeKalb	John C. Harvey, Auburn	Arnold D. Ducanes, 215 N. Franklin St., Greensburg 47240
Delaware-Blackford	David J. Dietz, Muncie	Harland V. Hippensteel, 208 W. 7th St., Auburn 46706
Dubois	Allen D. Scales, Huntingburg	Chas. J. Leiphart, 320 W. Adams St., Muncie 47305
Elkhart	Donald L. Minter, Goshen	Phillip R. Dawkins, 507 W. 7th St., Jasper 47546
Fayette-Franklin	Joseph L. Steinem, Connersville	Page E. Spray, 320 W. High St., Elkhart
Floyd	William V. Craft, New Albany	Kirit T. Patel, 1941 Virginia Ave., Connersville 47331
Fountain-Warren	Hugh C. Brenner, Williamsport	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fulton	James P. Schalliol, Rochester	Theodore Person, 601 N. Mill St., Veedersburg
Gibson	William Wells, Princeton	Joseph D. Richardson, 121 West 8th St., Rochester 46975
Grant	L. J. Wojcik, Marion	Hassan Rayes, 1814 Sherman Dr., Princeton 46760
Greene	Robert Moses, Warthington	E. S. Rifner, Van Buren
Hamilton	A. Adrian Lanning, Noblesville	Harry Roiman, Jasonville
Hancock	Carl K. Matlock, Greenfield	Paul M. Waitt, 450 Lafayette Rd., Noblesville 46060
Harrison-Crawford	Louis M. Blessinger, Corydon	Gary C. Sharp, 120 W. McKenzie, Greenfield 46140
Hendricks	Joseph Kerlin, Danville	Carl E. Dillman, Beaver & Oak St., Corydon 47112
Henry	David Cain, New Castle	Wm. A. Edwards, 1655 Hawthorn Dr., Plainfield 46168
Howard	G. M. Reul, Kokomo	Donald E. Vivian, Henry Co. Hospital, New Castle 47362
Huntington	William J. Webb, Huntington	Donald L. Fields, 3804 Southland Ave., Kokomo 46901
Jackson	Mark M. Bevers, Seymour	Piyush J. Shah, 1159 Etna Ave., Huntington 46750
Jasper	Kenneth J. Ahler, Rensselaer	Joel M. McGill, 213 E. Cross St., Brownstown 47220
Jay	James S. Fitzpatrick, Portland	Michael Louck, 828 W. Washington Ave., Rensselaer 47978
Jefferson-Switzerland	Robert Mulford, Versailles	Joseph F. Vormohr, 604 W. Arch St., Portland 47371
Jennings	James L. Calli, North Vernon	Ott B. McAtee, Madison State Hospital, Madison
Johnson	Steven A. Weber, Franklin	F. Richard Walton, 311 Henry St., North Vernon 47265
Knox	Frederick H. Buehl, Vincennes	Chandrabhan Singh, Johnson Co. Memorial Hospital, Franklin 46131
Kosciusko	David W. Haines, Warsaw	Phillip B. Kinman, 609 Dubois St., Vincennes 47591
LaGrange	Millard R. Taylor, Howe	George A. Ros, 827 S. Union St., Warsaw 46580
Lake	Thomas A. Gehring, Merrillville	Evan C. Thompson, P.O. Box 217, Topeka 46571
LaPorte	Barbara Backer, LaPorte	Mary E. Carroll, 124 N. Main St., Crown Point 46307
Lawrence	Gerald E. Kasting, Bedford	Mr. John B. Twyman, Ex. Dir., 6685 Broadway, Merrillville 46410
Madison	Kenneth E. Schemmer, Anderson	Robert M. Kelsey, 1200 Michigan Ave., LaPorte 46350
Marion	George T. Lukemeyer, Indianapolis	Orville A. Schumm, Exec. Dir., 110 South Ave., LaPorte 46350
Marshall	Michael F. Deery, Culver	Gareth A. Morgan, 1618—24th St., Bedford 47421
Miami	Maurice Sixbey, Denver	John D. Jones, 1719 N. Madison Ave., Anderson 46012
Montgomery	Fred P. Warbinton, Crawfordsville	George H. Rawls, 3151 N. Illinois St., Indianapolis 46208
Morgan	O. R. Wilson, Morgantown	Mr. Harold W. Hefner, Exec. Dir., 211 N. Delaware St., Indianapolis 46204
Newton	R. S. Jardenil, Kentland	Byron Holm, 304 N. Walnut, Plymouth 46563
Noble	John E. Ramsey, Kendallville	A. L. Baluyut, 29 E. Main, Peru 46970
Orange	Charles X. McCalla, Paoli	Jack L. Foltz, 1407 Darlington Ave., Crawfordsville 47933
Owen-Monroe	William R. Anderson, Bloomington	Stephen L. Hardin, 171 E. Washington St., Martinville 46151
Parke-Vermillion	George Alexandrescu, Clinton	E. L. Gamba, Lake Village 46349
Perry	Robert Gilbert, Tell City	Carl F. Stallman, R.R. 3, Kendallville 46755
Pike	Donald L. Hall, Petersburg	Philip T. Hodgins, Orleans
Porter	James R. Brown, Valparaiso	Mark Wisen, 619 W. First, Bloomington 47401
Posey	Harold E. Ropp, New Harmony	Arlene Rhea, Exec. Secy, 1920 E. Third St., Bloomington 47401
Pulaski	Harold J. Halleck, Winamac	J. Franklin Swaim, P.O. Box 185, Rockville 47872
Putnam	Fred Haggerty, Greencastle	Robert A. Ward, Professional Bldg., Tell City
Randolph	Jerome M. Leahey, Union City	Donald L. Hall, 7th and Poplar, Petersburg 47567
Ripley	Manuel G. Garcia, Batesville	Uldarico B. Blando, 802 LaPorte Ave., Valparaiso 46383
Rush	Davis W. Ellis, Rushville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
St. Joseph	Richard Schaphorst, Mishawaka	William R. Thompson, 111 N. Monticello St., Winamac 46996
Scott	Benjamin V. Roberto, Austin	F. R. Dettloff, 407 Melrose Ave., Greencastle 46135
Shelby	Lucian A. Arata, Shelbyville	C. R. Miranda, 702 Browne St., Winchester 47394
Spencer	Michael O. Monar, Rockport	Thomas E. LeBeau, Margaret Mary Hospital, Batesville 47006
Starke	Walter Fritz, Knox	Harry G. McKee, 208 W. First St., Rushville 46173
Steuben	Donald Mason, Angola	Richard Buck, 51916 U.S. 31 North, South Bend 46615
Sullivan	John R. Taylor, Palestine	Mrs. Rose Vance, Exec. Secy., 2015 Western Ave., South Bend 46629
Tippecanoe	Altamont Bracey, Lafayette	Manuel T. Dancel, 675 N. Gardner St., Scottsburg 47170
Tipton	Destroy W. Lambert, Tipton	Dar Muceno, 103 W. Washington, Shelbyville 46176
Vanderburgh	Wallace M. Adye, Evansville	John C. Glackman, Jr., Rockport
Vigo	Tom J. Conway, Terre Haute	Earl Leinbach, Hamlet
Wabash	Charles R. Lyons, Wabash	K. L. Kissinger, 411 E. Eilmore St., Angola 46703
Warrick	Robert H. Terry, Boonville	Joe Dukes, South Third St., Dugger 47848
Washington	Charles B. Carty, Pekin	Robert Williamson, c/o 2424 Ferry St., Lafayette 47904
Wayne-Union	William R. Stilwell, Richmond	George L. Compton, 219 N. Independence, Tipton 46072
Wells	Louis F. Bradley, Bluffton	Mrs. Carole Rust, Exec. Dir., 421 N. Main St., Evansville 47711
White	Max L. Fields, Monticello	James W. Cristee, 400 8th Ave., Terre Haute 47804
Whitley	Claude J. Heritier, Columbia City	William L. Purcell, Exec. Secy., P.O. Box 986, Terre Haute
		Parks M. Adams, Jr., 1103 N. Wayne St., N. Manchester 46962
		Carlos M. Ruiz, 123 S. Second St., Boonville 47601
		Thomas R. Northcott, 102 N. Harrison, Salem 47167
		Richard M. Butler, Reid Memorial Hospital, Richmond 47374
		James E. Umphrey, 303 S. Main St., Bluffton 46714
		Nolan A. Hibner, 222 S. Main St., Monticello 47960
		John Vogel, 215 E. Van Buren, Columbia City 46725

Reference Committees

Reference Committee No. 1—Reports of Officers

GS	Thomas C. Tyrrell, M.D., Chairman, Calumet City
GP	Jack Higgins, M.D., Kokomo
GP	Joseph Young, M.D., Greenwood
IM	Douglas White, M.D., Indianapolis
GP	Richard Schaphorst, M.D., Mishawaka
GP	John Guttman, M.D., Wakarusa (ALTERNATE)

Reference Committee No. 2—Constitution and Bylaws

GS	Richard Brickley, M.D., Chairman, Indianapolis
PD	G. Beach Gattman, M.D., Elkhart
UR	Paul Humphrey, M.D., Terre Haute
GP	Charles Egnatz, M.D., Schereville
PTH	Charles Aust, M.D., Fort Wayne (ALTERNATE)

Reference Committee No. 3—Legislative

RAD	L. Ray Stewart, M.D., Chairman, Evansville
P	Shirley Khalouf, M.D., Marion
GP	Leonard Neal, M.D., Munster
GP	Charles McClary, M.D., Bloomington
OB	Paul Muller, M.D., Indianapolis
OS	Gilbert Gutwein, M.D., Lafayette (ALTERNATE)

Reference Committee No. 4—Medical Education and Insurance

GP	Fred Dahling, M.D., Chairman, Fort Wayne
GS	George Rawls, M.D., Indianapolis
GP	Peter Guttierrez, M.D., Crown Point
GP	George Underwood, Lafayette
GP	Thomas Hamilton, M.D., Columbia City
IM	George Lukemeyer, M.D., Indianapolis (ALTERNATE)

Reference Committee No. 5—Miscellaneous

GP	Davis Ellis, M.D., Chairman, Rushville
PD	Helen Czenkusch, M.D., Indianapolis
GP	Max Hoffman, M.D., Covington
IM	Beverly Maxam, M.D., Indianapolis
IM	Lee Dupler, M.D., Frankfort
GP	Michael Mellinger, M.D., LaGrange (ALTERNATE)

Reference Committee No. 6—AMA Matters

GP	Peter Petrich, M.D., Chairman, Attica
IM	Patrick J.V. Corcoran, M.D., Evansville
OBG	Nicholas Polite, M.D., Whiting
GP	Kenneth Gray, M.D., Indianapolis
GS	Robert Bills, M.D., Gary
OBG	David Ryan, M.D., Columbus (ALTERNATE)

Tellers

Robert Oehler, M.D., Brazil
William VanNess II, M.D. Summitville
John Luce, M.D., Michigan City
Walfred Nelson, M.D., Gary

Rules and Order of Business

L. Ray Stewart, M.D., Chairman, Evansville
Richard Brickley, M.D., Indianapolis
Thomas C. Tyrrell, M.D., Calumet City
Fred Dahling, M.D., New Haven
Davis Ellis, M.D., Rushville

Credentials Committee

John Knotte, M.D., Lafayette, Chairman
Cleon Schauwecker, M.D., Greencastle
Howard Jackson, M.D., Madison
Alvin Haley, M.D., Fort Wayne
Robert M. Brown, M.D., Marion

Resolutions

Resolution No. 78-1

Introduced by: Subcommittee on Aging

Subject: ISMA SPECIALTY SECTION OF MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES

Referred to:

Whereas, Geriatric medicine has become an increasing factor in the care of patients; and

Whereas, Extended care and long-term health care facilities have become an important factor in the delivery of health care; and

Whereas, Medical direction of these facilities involve problems peculiar to their proper function; and

Whereas, The medical direction is the province of physicians who serve as medical directors of these facilities; now, therefore be it

Resolved, That the ISMA establish a Section of Medical Directors and Staff Physicians of Nursing Facilities whose purpose will be:

1. To organize and implement guidelines for pertinent medical care;
2. To disseminate this information throughout the Section;
3. To reduce the record-keeping to workable standards;
4. To keep the rules and regulations within practicable standards of uniformity; and
5. To acquaint the Medical Directors with new procedures that improve the patient care.

Resolution No. 78-2

Introduced by: Gregory N. Larkin, M.D.

Subject: BLOOD PRESSURE MEASUREMENT AS STANDARD PROCEDURE

Referred to:

Whereas, High blood pressure is a national and state-wide foremost health problem with one in every six adults estimated to have the disease; and

Whereas, High blood pressure has been described as a "silent killer" responsible as a major risk factor in many of the 850,000 deaths annually caused by heart attack and stroke; and

Whereas, High blood pressure can be detected by a simple, inexpensive and painless test and, in most cases, can be controlled with medication; now, therefore be it

Resolved, That:

"Blood pressure measurement should be a standard procedure for any routine office visit."

Resolution No. 78-3

Introduced by: Howard County Medical Society

Subject: FUNDS FOR BOARD OF MEDICAL LICENSURE

Referred to:

Whereas, The Indiana Board of Medical Registration and Examination has found it difficult to investigate and prosecute instances of illegal medical practice and immoral conduct of medical practitioners due to a lack of funds; and

Whereas, Fees collected by the Board for annual registration of physicians are put into the general fund of the State of Indiana instead of a dedicated fund which could be used by the Board to fund its proper operation; now, therefore be it

Resolved, That the ISMA House of Delegates instruct the Board of Trustees to prepare a bill and cause it to be introduced in the next session of the Indiana General Assembly that would place the monies derived from the annual license renewal fees into a dedicated fund which could be used only by the Board of Medical Registration and Examination for its proper operation.

Resolution No. 78-4

Introduced by: Vigo County Medical Society

Subject: FREE CHOICE OF PHYSICIAN

Referred to:

Whereas, The medical profession in the State of Indiana has always been for the free choice of physician by the patient; and

Whereas, The Workmen's Compensation Law of the State of Indiana takes this choice of physician away from the patient and gives it to the employer or his compensation insurance carrier; and

Whereas, Senate Bill 183 of the 1978 State Legislature would have returned this choice to the patient if it had passed, now, therefore be it

Resolved, That the Indiana State Medical Association support the free choice of physician by the patient and actively support such a bill as Senate Bill 183 if one is introduced in the 1979 Legislature.

Resolution No. 78-5

Introduced by: Clark County Medical Society

Subject: OPPOSITION TO ISMA OFFICERS SERVING ON PSRO BOARD

Referred to:

Resolutions

Whereas, The Indiana State Medical Association, through our House of Delegates, has repeatedly voiced our philosophical objection to PSRO; and

Whereas, At present many officers of ISMA currently serve on the boards of PSRO; and

Whereas, Those who tout PSRO are using this fact to their advantage; and

Whereas, The objectives of PSRO and the objectives of ISMA are diametrically opposite, thereby causing a conflict of interest; now, therefore be it

Resolved, That this House of Delegates recommends that no officer of the Indiana State Medical Association serve in any official capacity on any board of any PSRO, and that the Indiana State Medical Association reaffirm their position of opposition so that any M.D. serving on a PSRO board does so as an individual and should resign his office in ISMA.

Resolution No. 78-6

Introduced by: Commission on Medical Services

Subject: ISMA SPOKESPERSON

Referred to:

Whereas, There are an ever increasing number of daytime governmental meetings where professional expertise is needed when health matters are discussed; and

Whereas, Without such professional input good medical decisions cannot be made; now, therefore be it

Resolved, That ISMA solicit six ISMA members who have a thorough understanding of the health care delivery system and ISMA policies, are good communicators and listeners, and are either experienced in or interested in becoming knowledgeable in negotiations; and be it further

Resolved, That those physicians selected be directly accountable and responsible to the Board of Trustees; and be it further

Resolved, That these physicians attend designated meetings (day or night) when professional expertise is needed; and be it further

Resolved, That these physicians work closely with the Director of Health Services Planning in staying informed on all government decisions and documents concerning health, developing comments and/or reports on key issues; and be it further

Resolved, That these physicians maintain close liaison with physicians serving on HSA boards, subarea councils and committees; and be it further

Resolved, That these physicians submit written or oral reports to the Board of Trustees regarding all governmental meetings attended.

Resolution No. 78-7

Introduced by: Commission on Medical Education

Subject: MEDICAL STUDENT COMPONENT SOCIETY

Referred to:

Whereas, The Bylaws of the Indiana State Medical Association, as adopted at the annual meeting in 1977, call for representation of the entire student body of Indiana University School of Medicine rather than through AMSA; and

Whereas, The Bylaws call for a student delegate and alternate, but without a system established for their election; now, therefore be it

Resolved, That Chapter 1, Section 3, Paragraph I of the Bylaws be amended by adding a new paragraph as follows:

"The Student Council of the Indiana University School of Medicine shall elect a student delegate and alternate delegate from nominees presented to them from each class. All resolutions introduced in the name of the student body must be presented through the Student Council functioning as the executive body of the student members—in effect, a student component society."

Be it further

Resolved, That the election of delegates and alternate delegates should be made with consideration of maximum continuity of student representation.

Resolution No. 78-8

Introduced by: Marion County Medical Society

Subject: UNIFORM HEALTH INSURANCE CLAIM FORM

Referred to:

Whereas, A Uniform Health Insurance Claim Form has been developed to maximize the efficiency of physicians' filing of medical care claims to benefit the patient through timely adjudication of claims; and

Whereas, Blue Cross and Blue Shield of Indiana, as fiscal agent for Medicaid in Indiana, declines to accept the Uniform Health Insurance Claim Form, thereby causing delay in reimbursement in behalf of patients; and

Whereas, The resultant delays diminish the ability of physicians to accept Medicaid patients; and

Whereas, Similar inconsistencies in required filing procedures work to the disadvantage of other third-party paid patients; now, therefore be it

Resolved, That the Indiana State Medical Association adopt the Uniform Health Insurance Claim Form

Resolutions

as developed or as it may be amended by the American Medical Association, and encourage its acceptance and use by Medicare, Medicaid, CHAMPUS, and other third-party carriers in Indiana.

Resolution No. 78-9

Introduced by: Marion County Medical Society

Subject: ADMISSION TO AMA PROGRAMS AND SEMINARS

Referred to:

Whereas, The American Medical Association develops educational programs and seminars for the benefit of physicians and organizations within the Federation; and

Whereas, Attendance at such programs and seminars by non-physicians, not affiliated with the Federation, is not subject to approval of component and state associations; and

Whereas, The success of AMA programs and seminars may in fact work to the disadvantage of the component and state associations and their members; now, therefore be it

Resolved, That the American Medical Association Board of Trustees and appropriate Council study the potential negative effects of admission of non-physician, non-Federation affiliated personnel to AMA programs and seminars without approval of the potentially affected component and/or state association.

Resolution No. 78-10

Introduced by: Marion County Medical Society

Subject: SPEAKER OF THE HOUSE IN AMA DELEGATION

Referred To:

Whereas, The House of Delegates is the crucible in which Indiana State Medical Association policies are forged; and

Whereas, The ISMA Delegation to the American Medical Association has the obligation to reflect the attitude of Indiana physicians; and

Whereas, The Speaker of this House of Delegates, as its elected Chairman, can and should augment the breadth and depth of the ISMA Delegation before the House of Delegates of the American Medical Association; now, therefore be it

Resolved, That the Speaker of the ISMA House of Delegates serve as a member of the ISMA Delegation to the AMA and be reimbursed for travel accordingly.

Resolution No. 78-11

Introduced By: Marion County Medical Society

Subject: SECOND OPINIONS

Referred To:

Whereas, The advisability of any specific therapy, medical or surgical, is a matter of professional opinion; and

Whereas, Historically physicians have recognized the value of consultation; and

Whereas, Third-party payors, including state and federal governments, are beginning to seek mandatory second opinions for all elective surgical procedures; now, therefore be it

Resolved, That the Indiana State Medical Association supports the right of a patient or physician to seek consultation freely with any consultant of his or her choice and opposes the concept of mandatory consultation required by third-party payors; and be it further

Resolved, That the Indiana State Medical Association supports the concept of qualified and necessary consultants and opposes the concept of panels of consultants, open or closed; and be it further

Resolved, That the Indiana State Medical Association supports the concept that when second or more opinions are mandated by any party, this party is responsible for the consultant fee and related tests and the choice of consultant is the responsibility of the patient and/or the attending physician; and be it further

Resolved, That the Indiana State Medical Association vigorously opposes the misconception that a second opinion is more valid than the first.

Resolution No. 78-12

Introduced By: Marion County Medical Society

Subject: MEMBERSHIP RECRUITMENT—DUES REDUCTION

Referred To:

Whereas, Research commissioned by the American Medical Association has disclosed advantages to membership recruitment through reduction of dues in the early years of practice; and

Whereas, The American Medical Association has acted to reduce by one-half the dues for AMA membership for physicians in their first year of practice following formal training; and

Whereas, The results of the research conducted by the American Medical Association should be equally applicable to the membership recruitment activities

Resolutions

of the Indiana State Medical Association; now, therefore be it

Resolved, That the Indiana State Medical Association dues for active members in their first year of practice shall be one-half the amount as may be established by the House of Delegates.

TO: HOUSE OF DELEGATES
FROM: CHAIRMAN OF THE EXECUTIVE COMMITTEE
RE: STUDENT LOAN FUND

The Board of Trustees voted in 1957 to recommend to the House of Delegates that dues be increased by the sum of \$10 per member, specifically for the American Medical Education Foundation (AMA-ERF). In 1963, a resolution was passed which provided for a realignment of the dues structure. Essentially it provided that half of that amount, or \$5, be allocated to fund the Student Loan Program.

The Student Loan Fund is a separate charitable trust established in 1955 for the purpose of making loans to medical students. Under the Student Loan program agreement, there is a provision that requires the Association to maintain in the account a sum of not less than 8% of the aggregate of outstanding loans, including interest or a constant maximum of \$40,000. Since this maximum has long since been achieved, the \$5 annual dues allocation for the Student Loan Program reverts to the General Fund, along with accumulated interest.

Under the terms of an agreement with the Indiana National Bank, Indianapolis, the bank makes loans to students enrolled and in satisfactory standing at the Indiana University Medical School at the rate of \$12.50 for each dollar placed in a capital reserve at the bank. The bank held \$20,810 in the capital reserve on Sept. 30, 1977 (represented by certificates of deposit), thereby producing an available loan balance approximating \$260,000. There are no outstanding loans at present.

The Executive Committee, in conjunction with the Student Loan Committee, reviews the student loan situation annually for the purpose of authorizing further general fund appropriations to the loan fund as additional funds are needed to guarantee loans under the agreement with the bank.

Earlier this year, the Executive Committee reviewed the status of the Student Loan Program and found that the overall demand for student loans has declined during the past several years primarily due to the adequacy and availability of federal funds. Also, other loan guarantee programs from such sources as the AMA-ERF and the Robert Wood Johnson Foundation are

readily available. In actual fact, there appears to be little if any demand for continuation of ISMA's loan program.

Accordingly, the Executive Committee recommends to the House of Delegates that the Student Loan Program be terminated and that the amount remaining in the Student Loan Fund revert to the General Fund. (See Resolution 78-13 below)

Resolution No. 78-13

Introduced by: ISMA Executive Committee
Subject: STUDENT LOAN PROGRAM
Referred to:

For reasons outlined in the report to the House of Delegates from the Chairman of the Executive Committee (above) concerning the Student Loan Fund;

Resolved, That the Student Loan Program be terminated, retroactive to the end of the fiscal year, Sept. 30, 1978, and that the amount remaining in the Student Loan Fund revert to the General Fund; and be it further

Resolved, That Section 4 of Chapter VIII, entitled "Executive Committee" be deleted and Section 5 be renumbered Section 4; and be it further

Resolved, That this matter be referred to the Commission on Constitution and Bylaws 30 days in advance of the first meeting of the October 1978 House of Delegates in accord with Chapter XVIII of the Bylaws to insure consideration by the House.

Resolution No. 78-14

Introduced by: Vanderburgh County Medical Society
Subject: CONTINUOUS CARE IN HEALTH CARE FACILITIES
Referred to:

Whereas, A physician is the appropriate means of entry into the health care system; and

Whereas, He is best able to evaluate the patient's total health needs, to provide basic personal medical care, and when indicated to refer the patient to appropriate sources of care, while preserving continuity of care; and

Whereas, He assumes responsibility for the patient's comprehensive and continuous health care, acting as a coordinator of the patient's health services when needed; and

Whereas, A patient, who in good faith entrusts his health care to a medical facility which functions for

CONTINUED ON PAGE 920

Scientific Exhibits

George T. Lukemeyer, M.D., Indianapolis, Chairman

ROLE OF THE COMMUNITY HOSPITAL IN CADAVERIC ORGAN PROCUREMENT FOR TRANSPLANTATION

Exhibitor: Ronald S. Filo, M.D.
Indianapolis
Co-exhibitors: Stephen B. Leapman, M.D.
Edwin J. Smith, M.D.
Indianapolis
Attendants: Dave Mainous
Diane Dirksen

The purpose of this exhibit is to demonstrate the essential role of community hospitals throughout Indiana in obtaining sufficient numbers of kidneys for transplantation.

The exhibit is a series of illuminated color transparencies presented in a logical format: 1) a factual documentation of the problem, i.e., a need for more cadaveric organs; 2) the role of the Indiana Medical Community in aiding the Transplant Centers in the procurement of cadaveric organs; 3) documentation of a four-year experience of the IUMC-VA Transplant Program in cooperating with local community hospitals in the area of organ procurement.

The exhibit points out that End Stage Renal Disease, a major health problem, is throughout the state of Indiana.

If transplantation is to be a viable alternative for the treatment of End Stage Renal Disease, then the community hospital must assume a greater responsibility in providing cadaveric organs for transplantation.

MICROSURGICAL VASOVASOSTOMY COM- PARED TO STANDARD TECHNIQUES: A CLOSER LOOK

Exhibitor: Arnold M. Belker, M.D.
Louisville, Kentucky
Co-exhibitors: Robert D. Acland, M.D., Louisville
Thomas L. Roberts, III, M.D.
Charlottesville, Virginia
Mark S. Sexter, M.D., Louisville
Attendee: Arnold M. Belker, M.D.

Markedly improved results of vasectomy reversal with the use of microsurgical methods have been reported recently. This exhibit demonstrates the recently described two-layer microsurgical anastomotic technique, and also demonstrates a method of preservation of human vas deferens segments for laboratory microsurgical practice. Several types of anastomoses were performed on such laboratory segments, both with and

without the use of the operating microscope. The anastomosed vas segments then were opened longitudinally and examined under the operating microscope.

A visual photographic comparison suggests that the microsurgical two-layer anastomosis best restores anatomical continuity. Results with the new microsurgical method are compared to previous results with standard anastomotic techniques.

INFANT SCALP I.V.: A TEACHING SIMULATOR

Exhibitor: William L. Hildebrand, M.D.
Department of Family Practice
I. U. School of Medicine
Indianapolis
Co-exhibitors: Robert D'Agostino, M.D.
Craig Gosling, B.S.
Charles Sternecker, M.A.
Richard L. Schreiner, M.D.
Indianapolis
Attendants: Robert D'Agostino, M.D.
William L. Hildebrand, M.D.

Any physician caring for newborns should be capable of placing a peripheral I.V. needle. All premature infants less than 1,500 grams or less than 34 weeks gestation should have a peripheral I.V. started immediately after birth for at least the first 24-48 hours. In addition, peripheral I.V.s are indicated for administering intravenous fluids to infants not able to take adequate fluids via the gastric route, for administration of intravenous antibiotics for infants with possible sepsis or meningitis, and for treatment of symptomatic hypoglycemia in the newborn.

Although the umbilical vessels are easily accessible in the newborn, it is highly undesirable to use either the umbilical artery or the umbilical vein solely for the purpose of I.V. fluid therapy. Cutdowns in the newborn are rarely indicated. Hypodermoclysis is never indicated in pediatrics and may cause serious fluid shifts in patients with already borderline fluid and electrolyte status.

Although the technique of intravenous needle placement is easy to demonstrate on live infants, it is difficult for physicians and nurses at community hospitals to acquire the necessary skills, unless there is a sick newborn requiring intravenous needle placement and an instructor readily available for teaching purposes. Therefore, a teaching simulator has been developed. Physicians will be able to practice the technique of intravenous needle placement. In addition, an illustrated handout describing the technique will be provided.

Scientific Exhibits

NON-INVASIVE DIAGNOSTIC TECHNIQUES FOR PERIPHERAL VASCULAR DISEASE

- Exhibitor:* Phillip J. Bendick, Ph.D.
Wishard Memorial Hospital
Indianapolis
- Co-exhibitor:* John L. Glover, M.D.
Indianapolis
- Attendants:* Carol Kempf
Robert Plawewski

The vascular laboratory is established to evaluate the functional capacity of the peripheral vascular system and diagnose peripheral vascular disease. Utilizing non-invasive techniques, its procedures and instruments are used to document the presence and severity of disease in the upper and lower extremities and the cerebral vascular system. Specifically, the laboratory can help the physician diagnose venous thrombosis, extracranial vascular disease, and arterial occlusive disease in the trunk and extremities. Additionally, it is hoped these techniques will provide a more detailed picture of the natural history, progression, and characteristics of peripheral vascular disease.

Vascular laboratory data are an objective functional assessment which usually complement the anatomic date of arteriography or venography but, in some instances, obviate the need for these studies. The instrumentation used includes the ultrasound Doppler flowmeter, strain gauge of pneumoplethysmography, Phonoangiography, oculoplethysmography and photoplethysmography. With these techniques, it is possible to assess the functional capacity of the vascular system and evaluate in an atraumatic fashion circulatory disorders brought about by arterial or venous disease.

MEDICAL EDUCATIONAL RESOURCES PROGRAM, INDIANA UNIVERSITY SCHOOL OF MEDICINE

- Exhibitor:* Medical Educational Resources Program,
Indiana University School of
Medicine, Indianapolis
- Attendant:* John Whitaker
Indianapolis

Continuing medical education is offered to Indiana's medical community through the School of Medicine's statewide, closed circuit color Medical Television Network.

The Medical Television Network broadcasts live and videotaped programs weekdays, eight hours a day to over 40 hospitals throughout the state via Indiana University's seven Instructional Television Fixed Service

stations, the Indiana Higher Education Telecommunication System, and private cable television (CATV) companies.

All programming originates from WAT 21, a 2-channel station at the Medical Center in Indianapolis. An ITFS station at Dyer, Indiana, licensed to Indiana University, rebroadcasts programming to hospitals in the northwest portion of the state.

In addition, special arrangements with cable television companies have allowed physicians in certain areas to receive medical programs in their homes.

The exhibit will display videotape programming, WAT 21 TV Guides, and maps depicting the various continuing medical education television networks.

INDIANA UNIVERSITY MEDICAL SCHOOL DIABETES RESEARCH AND TRAINING CENTER:

HELPING THE PRACTICING PHYSICIAN CARE FOR HIS PATIENTS WITH DIABETES

- Exhibitor:* Charles M. Clark, Jr., M.D.
Regenstrief Health Center
Indianapolis
- Co-exhibitors:* Frank Vinicor, M.D.
Stuart Cohen, M.D.
Mary Jane Lundberg
Edwin Fineberg, M.D.
- Attendants:* Charles Clark, M.D.
Edwin Fineberg, M.D.
Frank Vinicor, M.D.
Mary Jane Lundberg

The Diabetes Research and Training Center was established at Indiana University by a grant from the National Institutes of Health to promote research, training, and health professional education in the area of diabetes mellitus. The Center consists of research grants, both basic and clinical, a model demonstration unit, and training programs for health professionals. Of major interest to the practicing medical community, the Diabetes Research and Training Center also assists practicing physicians in translating the results of medical research and in improving care for their patients. The Diabetes Research and Training Center sponsors and cooperates with courses directed toward improving the ability of the practicing physician to care for his patients.

The exhibit is designed to inform the practicing physician of the activities of the Diabetes Research and Training Center. It is also hoped that visitors at the Center will discuss their views regarding how the Center's programs can be designed to most effectively assist the practicing physician in the care of his patients.

Scientific Exhibits

FIBER IMPLANTATION FOR THE TREATMENT OF PATTERN BALDNESS

Exhibitor: C. William Hanke, M.D.
The Cleveland Clinic Foundation
Cleveland, Ohio

Co-exhibitors: Wilma F. Bergfeld, M.D.
Sara Fleming
Cleveland Clinic, Cleveland

Attendant: C. William Hanke, M.D.

Fiber implantation is a new technique for the treatment of pattern baldness. Investigation of over 20 patients who had undergone the procedure revealed that nearly 100% of the fibers had fallen out by 10 weeks. Possible complications included marked facial swelling, infection, foreign body granulomas, scarring, and permanent hair loss. Scanning electron microscopy was used to identify the nature of the fibers. The complications and high monetary cost of fiber implantation make it an unacceptable therapy.

The exhibit will review a number of patients who have undergone the technique. Photographs of the complications will be presented.

It is important that all physicians view this exhibit because new offices for the fiber implantation procedure are being opened in many states. Increased physician and public awareness will hopefully reduce the number of individuals who will be harmed by fiber implantation.

MOHS' CHEMOSURGERY FOR THE TREATMENT OF SKIN CANCER

Exhibitor: Philip L. Bailin, M.D.
Department of Dermatology
The Cleveland Clinic
Cleveland, Ohio

Co-exhibitors: C. William Hanke, M.D.
Sara Fleming
Cleveland Clinic, Cleveland

Attendant: C. William Hanke, M.D.

Approximately 500,000 skin cancers are reported yearly in the United States. 5-8% or 25-40,000 of these will recur at least once. Dr. Frederic Mohs of the University of Wisconsin has developed a highly reliable method for the removal of recurrent skin cancers. This method, known as Mohs' chemosurgery, is a microscopically controlled excision of the cancerous tissue.

The exhibit will review the indications and advantages of Mohs' chemosurgery for skin cancer. The Mohs' technique will be described using both the fixed and fresh tissue methods.

The results of treatment using Mohs' chemosurgery for recurrent basal cell carcinoma will be compared with results using more commonly used methods such as surgical excision, x-ray, cryosurgery, and curettage.

Physicians viewing the exhibit will be able to choose more effectively between the various methods of skin cancer treatment.

ULTRASONOGRAPHY IN OBSTETRICS AND GYNECOLOGY

Exhibitor: United States Navy
575 North Pennsylvania St.
Indianapolis, Ind. 46204

Co-exhibitor: Naval Health Education Training
Command
Bethesda, Maryland 20014

Attendants: Robert Jones
Ralph Havranek
Harvey Randolph

The exhibit entitled "Ultrasonography in Obstetrics and Gynecology" is designed to focus attention on the usefulness of ultrasonography in the specialty of obstetrics and gynecology. The increasing sophistication of ultrasonography and the usefulness of this technique in our specialty was affirmed in the ACOG Newsletter (July 1976): "All hospitals intending to provide care for high risk obstetric patients should have an ultrasonographic unit."

The exhibit consists of three major panels. Two-side panel exhibits with transparencies show the normal anatomic structures of the pregnant and nonpregnant pelvis with diagrams indicating routine ultrasonic planes. These planes are then illustrated in 8×10 enlargements of typical ultrasound views. In addition, there are several transparencies indicating major abnormalities and their sonographic appearance. The center panel consists of a 35mm slide show exhibiting major abnormalities of the pregnant and nonpregnant state with clinical correlation using photographs, artist conceptions and x-rays. The case material is designed to cover major diagnostic abnormalities seen in the specialty of obstetrics and gynecology.

Technical Exhibits

ABBOTT LABORATORIES, 14th and Seridan Road
North Chicago, Ill. 60064

Exhibit will feature Tranxene (Clorazepate dipotassium) and Ogen (piperazine estrone sulfate) products.

BOEHRINGER INGELHEIM LTD.

90 East Ridge, P.O. Box 368

Ridgefield, Conn. 06877

Exhibit will feature Catapres (clonidine hydrochloride), Combipres (clonidine hydrochloride 0.1 mg. or 0.2 mg. + chlorthalidone 15 mg.), and Alupent (metaproterenol sulfate).

BRISTOL LABORATORIES

P.O. Box 657

Syracuse, N.Y. 13201

Exhibit will feature a wide variety of Bristol drug products.

THE CENTRAL PHARMACAL COMPANY

110-128 East Third Street

Seymour, Ind. 47274

Exhibit will feature Theoclear—the only clear choice in Anhydrous Theophylline Therapy, available in three dosage forms.

Jerry Wolfe, Bob Toerne, Sid Kemper

CIBA PHARMACEUTICAL COMPANY

556 Morris Avenue

Summit, N.J. 07901

Exhibit will feature Apresazide and Apresoline for hypertension and Slow-K—Oral potassium supplement.

R. K. Kitterman, Phil Cash

CLAYTON L. SCROGGINS ASSOCIATES, INC.

200 Northland Blvd.

Cincinnati, Ohio 45246

Exhibit will feature professional practice management and financial planning for doctors.

Lee W. Scroggins, David C. Scroggins or Clayton L. Scroggins

CONTI COMMODITY SERVICES, INC.

463 Wabash Village West

West Lafayette, Ind. 47906

Exhibit will feature information on Commodity Futures Industry.

Jim Bower, Bob Hamilton, Nick Brown, Jim Funk

COOPER LABORATORIES, INC.

259 Route 46

Parsippany, N.J. 07054

DISTA PRODUCTS COMPANY

P.O. Box 618

Indianapolis, Ind. 46206

ELECTROPEDIC PRODUCTS

907 Hollywood Way

Burbank, Calif. 91505

Exhibit will feature Sanyo—Therapeutic Professional Massager.

Mark Friedman, Ingrid Wecker, Marty Dodge

ELI LILLY & COMPANY

P.O. Box 618

Indianapolis, Ind. 46206

ENCYCLOPAEDIA BRITANNICA

425 North Michigan Ave.

Chicago, Ill. 60611

Exhibit will feature the 30 volume Britannica 3, the Britannica Junior and other related products.

Peter Johnson

HOECHST-ROUSSEL PHARMACEUTICALS, INC.

Route 202-206 North

Somerville, N.J. 08876

IMMKE CIRCLE LEASING, INC.

32 South Fifth St.

Columbus, Ohio 43215

Exhibit will feature automobile leasing.

Clarence E. Fox, Tom Harrison

INTERNATIONAL MEDICAL ELECTRONICS

2805 Main St.

Kansas City, Mo. 64108

Exhibit will feature Magnatherm—short wave diathermy equipment with two detachable heads.

Rodger Mullen

J.E. HANGER OF INDIANA

1332 North Illinois St.

Indianapolis, Ind. 46202

Exhibit will feature prostheses—components.

Steve Tyrrell, Richard Crouse, James Wolf

THE MEDICAL PROTECTIVE COMPANY

P.O. Box 15021

Ft. Wayne, Ind. 46815

Exhibit will feature Professional Liability Insurance

Kenneth W. Moeller, Douglas Sellon

MERCK SHARP & DOHME, INC.

West Point, Pa. 19486

MILEX OF INDIANA

1873 Grove Street

Glenview, Ill. 60025

Exhibit will feature cancer detection, patient education books and gynecic specialties.

Charles A. Bonsell, James E. Eickhoff

Technical Exhibits

PHYSIO CONTROL CORPORATION

221 Aspen Way
Noblesville, Ind. 46060

REED & CARNRICK

30 Boright Ave.
Kenilworth, N.J. 07033
Exhibit will feature Kwell, Phazyme-95, and Procto-foam-HC.
Rick Kramer, Dick Koch

SEARLE LABORATORIES

P.O. Box 5110
Chicago, Ill. 60680
Exhibit will feature a variety of Searle products.
Steven Schweighardt, George Standley, Al Phillips

SMITH KLINE AND FRENCH LABORATORIES

1500 Spring Garden St.
Philadelphia, Pa. 19101

STUART PHARMACEUTICALS

3411 Silverside Road, P.O. Box 751
Wilmington, Del. 19897
Exhibit will feature Mylanta, Mylanta-II, and Hibiclens.

SYNTEX LABORATORIES, INC.

3401 Hillview Ave.
Palo Alto, Calif. 94304
Exhibit will feature pharmaceutical products.

TAB OF INDIANA, INC.

810 East 63rd Place
Indianapolis, Ind. 46220
Exhibit will feature filing systems.
D.J. McPhaig, John R. Rardon

Program—ISMA Auxiliary

President—Mrs. G. Beach Gattman, Elkhart
Chairman of ISMA Auxiliary Activities—Mrs. Everett Bickers, Floyds Knobs
Co-Chairman—Mrs. Joseph Mudd, Clarksville
Treasurer—Mrs. Joseph Bruckman, New Albany

Sunday, Oct. 22, 1978

2 to 5 p.m. *Tour of Churchill Downs and Locust Grove
(Meet in lobby of Marriott Inn)

Monday, Oct. 23, 1978

8:30 a.m. Exercise Demonstration and tour of Kentuckiana Sports Center
9 a.m. Registration, *Main Lobby, Marriott Inn*
10 to 3 p.m. *Tour of Wakefield Searce Galleries and Bakery Square
Lunch, *Claudia Sanders*
7:30 - 10:30 p.m. Cruise on the Belle of Louisville on the Ohio River
Buffet Dinner
Dancing
Dixieland Band

***By advance reservation only**

Tuesday, Oct. 24, 1978

9 a.m. Registration—*Kentuckiana Convention and Sports Center*
9:45 a.m. Open Board Meeting (All physicians' spouses welcome)
Merry Wives of Windsor, Marriott Inn
11:30 a.m. Cash Bar, *Palm Terrace (Poolside)*
Noon Luncheon, *Merry Wives of Windsor*
Costumes Through the Ages:
Presented by Actors Theatre of Louisville
2:30 p.m. How to Decorate with Prints, *at Frame House Gallery*
6 p.m. Reception for Fifty Year Club, *Merry Wives of Windsor*
6:30 p.m. President's Reception, *Palm Terrace (Poolside)*
7:30 p.m. President's Dinner, *Ballroom*

Wednesday, Oct. 25, 1978

Free Day

PHYSICIANS' DIRECTORY

INTERNAL MEDICINE

Offices for the doctors listed below are located at 3130 N. Meridian St., Indianapolis 46208; the switchboard number is 317-927-1221.

MERIDIAN MEDICAL GROUP

CARDIOLOGY

Richard M. Nay, M.D.
Warren E. Coggeshall, M.D.
Richard R. Schumacher, M.D.
William C. Elliott, M.D.

HEMATOLOGY—ONCOLOGY

Laurence H. Bates, M.D.
William M. Dugan, M.D.
James E. Schroeder, M.D.
Frank A. Workman, M.D.
Deborah S. Provisor, M.D.
Pediatrics

METABOLISM AND ENDOCRINOLOGY

William M. Holland, M.D.

GASTROENTEROLOGY

Robert D. Pickett, M.D.
B. T. Maxam, M.D.
Lee G. Jordan, M.D.
Martin P. Meisenheimer, M.D.

INTERNAL MEDICINE

Hunter A. Soper, M.D.
Douglas H. White, Jr., M.D.
Michael B. DuBois, M.D.
Nephrology
Michael P. Bubbs, M.D.
Robert L. Iverson, Jr., M.D.
Critical Care
Michael Zeckel, M.D.
Infectious Diseases

INFECTIOUS DISEASES

Thomas G. Slama, M.D.
NEUROLOGY
Norman W. Oestrike, M.D.
Charles Rehn, M.D.

NEUROSURGERY

By Appointment

Phone 925-4255

C. BASIL FAUSSET, M.D.

Neurological Surgery

1815 North Capitol Avenue

Indianapolis 46202

By appointment only

Phone 317-353-6800

BIO MEDICAL LABORATORY

5506 East 16th St., Suite 24

Indianapolis 46218

Bio-Feedback Training for Migraine and Tension Headache

KARL L. MANDERS, M.D.

JOHN S. MARKS, JR., M.D.

MALCOLM S. SNELL, M.D.

PLASTIC SURGERY

NEPHROLOGY & INTERNAL MEDICINE, INC.

Daniel J. Ahearn, M.D.

Thomas Wm. Alley, M.D., FACP

George W. Applegate, M.D.

Charles B. Carter, M.D.

William H. Dick, M.D., FACP

Theodore F. Hegeman, M.D.

Douglas F. Johnstone, M.D.

LeRoy H. King, Jr., M.D., FACP

2020 W. 86th St., #307, Indianapolis 46260 Ph: 317-844-9911

1633 N. Capitol, #722, Indianapolis 46202 Ph: 317-926-0757

Answering Service 926-3466

CLINICAL NEPHROLOGY, RENAL TRANSPLANTATION, HEMODIALYSIS, PERITONEAL DIALYSIS, HYPERTENSION, FLUID AND ELECTROLYTE IMBALANCE, CRITICAL CARE.

PLASTIC & HAND SURGERY CLINIC, INC.

1944 N. Capitol Ave.

Indianapolis 46202

"An office surgery facility"

Haroon M. Qazi, M.D.

Diplomate, American Board of Plastic Surgery

Phone: 317-923-4822

317-926-3466

HAND SURGERY

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

By appointment

Phone 317-783-1319

VIDYASAGAR S. TUMULURI, M.D., F.A.C.S., INC.

Diplomate American Board of Surgery

Acute & Reconstructive Hand Surgery

General Surgery

3530 S. Keystone, Suite 305

Indianapolis 46227

PHYSICIANS' DIRECTORY

PSYCHIATRY

JOHN H. GREIST, M.D.

Diplomate, Board of Neurology and Psychiatry

Specializing in Psychiatry

3231 North Meridian Street

Indianapolis 46208

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALLERGY

INDIANA ASTHMA & ALLERGY ASSOCIATES

Specializing in Chronic Severe Asthma

and

Adult and Pediatric Allergic Disorders

D. Duane Houser, M.D., Inc.

(317) 923-7650

and

Douglas J. Horton, M.D.

(317) 923-6990

1815 N. Capitol Avenue
Indianapolis, Indiana 46202

Diplomates, American Board
of Allergy & Immunology

Answering Service 926-3466

From the Indiana Court of Appeals

Malpractice Act Held Constitutional

A malpractice suit should be dismissed because the patient failed to comply with the terms of the state's medical malpractice act, an Indiana trial court ruled in upholding the statute's constitutionality.

A patient filed a malpractice suit and failed to comply with the Act's requirements to serve preliminary notice on the insurance commissioner, submit the claim to a medical review panel, and seek no more than \$500,000 in damages. The physician and the insurance commissioner moved to dismiss the suit, and the trial court granted their motion.

Reviewing the history of the malpractice in-

surance crisis in Indiana, the trial court said that the Act had received extensive public debate and analysis. The Act was an appropriate attempt by the legislature to address the crisis and insure the availability of medical malpractice insurance at affordable costs to physicians, the court said.

The court rejected each of the patient's claims that the Act was unconstitutional. The requirement that a medical review panel hear each claim, the limit of \$500,000 in recovery, the limitation on attorney's fees, the requirement that all evidence presented to the panel be written, and due process safeguards were all valid, the court said. —*Mansur vs. Carpenter (Ind. Cir. Ct., Hancock Co., Case No. 37281, April 6, 1978).*

Reprinted courtesy of THE CITATION, AMA, July 1, 1978.

OBITUARIES

Casper (Cap) Harstad, M.D.

Dr. Harstad, 80, died June 17 at his home in Rockville.

A native of North Dakota, Dr. Harstad was graduated from the University of North Dakota Medical College in 1924. He served in both world wars.

He had practiced medicine for more than 50 years, the last 40 in Rockville, and had served as Parke County Health Officer for 18 years. He was a senior member of ISMA, a member of its 50-Year Club, and a former secretary of the Parke-Vermillion County Medical Society.

Rollin H. Moser, M.D.

Dr. Moser, 81, an Indianapolis physician 40 years, died June 26 in Belleair Beach, Fla., where he had moved after his retirement 15 years ago.

A 1922 graduate of the University of Chicago and its Rush Medical College, he served as director of gastroenterology at General (now Wishard) Hospital and was also medical consultant at the West Tenth Street Veterans Administration Hospital; in 1930 he was president of the staff at Methodist Hospital.

Dr. Moser, a senior member of ISMA and a member of its 50-Year Club, was a Fellow of the American College of Physicians and a diplomate of the Board of Internal Medicine of Gastroenterology.

W. Russell Springstun, M.D.

Dr. Springstun, 72, an Evansville pediatrician for more than 30 years, died July 24 at Deaconess Hospital in Evansville. He was attending physician at the Hyland Donor Center in Indianapolis until last January.

He was a 1931 graduate of the University of Louisville School of Medicine and had been a senior member of ISMA since 1976. Dr. Springstun, a World War II veteran, was a past president of the Vanderburgh County Medical Society.

J. William McBride, M.D.

Dr. McBride, 40, a Michigan City pathologist, died of cancer June 30 in St. Anthony Hospital, Michigan City.

Board certified in anatomic pathology and clinical pathology, he had been head pathologist at Porter Memorial Hospital since 1970.

Dr. McBride was born in West Virginia, and received his medical degree from the West Virginia University School of Medicine in 1963. Prior to coming to Indiana, he served with the U.S. Air Force in Vietnam, and as chief of clinical pathology and officer-in-charge of the hematology branch at Lackland AFB, Texas.

He was a former president of the Porter County Medical Society, vice-president and then president of the Porter County Health Planning Council, a member of the American Association of Blood Banks and the Indiana Association of Pathologists, and a fellow in the American Society of Clinical Pathologists and College of American Pathologists.

Arthur N. Jay, M.D.

Dr. Jay, 68, a retired Indianapolis physician, died June 22 in Methodist Hospital.

A native of Marion, and a 1940 graduate of Indiana University School of Medicine, he served four years in the Army before establishing his medical practice in Indianapolis. He was an associate professor at the I. U. School of Medicine, was president of the Methodist Hospital staff in 1955, and served two three-year terms on the board of trustees and the liaison committee of the hospital. Following his retirement from private practice in 1969, he became vice-president and medical director of State Life Insurance Company. He retired from the firm in 1974 and for three years served as chief medical consultant of Indiana Rehabilitation Services.

Dr. Jay was also an enthusiastic amateur film maker, and had made hour-long films with music and commentary on foreign lands, which he presented before civic, church and senior citizens groups.

Byron K. Zaring, M.D.

Dr. Zaring, 72, a retired surgeon, died July 5 at the Bartholomew County Hospital in Columbus.

He was a 1930 graduate of the Indiana University School of Medicine, and began general practice in Columbus in 1935. Following four years of service with the Army Medical Corps during World War II, he returned to Columbus to specialize in surgery. Dr. Zaring retired in 1971 after 36 years of medical practice.

He was a past president and past secretary of the Bartholomew-Brown County Medical Society, and was active in the American Cancer Society.

Donald R. Hampshire, M.D.

Dr. Hampshire, 62, an Indianapolis physician, died July 6 in his home.

A 1942 graduate of the Indiana University School of Medicine, he had been in general practice in Indianapolis since 1947. He was chairman of the general practice division at Methodist Hospital, medical director of the Marion County Juvenile Center, and a member of the staff of St. Vincent Hospital. He served with the U. S. Army during World War II.

Dr. Hampshire was a member of the American Academy of General Practice and of the Phi Rho Sigma medical fraternity.

Opal L. Wood, M.D.

Dr. Wood, 71, a Clay County physician for more than 36 years, died July 8 at the Clay County Hospital, Brazil.

Born in Oklahoma while the state was still a territory, he was graduated from the University of Nebraska Medical School in 1931. He had practiced in Missouri before coming to Indiana in 1938.

In the Clay community, Dr. Wood was county coroner for a year, county health officer for several years, and president of the county medical society for a year. He retired in 1974.

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

1978 Annual Meeting—Oct. 22-25—Clarksville

OFFICERS FOR 1977-78

President—Eli Goodman, 807 High St., Charlestown 47111

President-Elect—James A. Harshman, M.D., St. Joseph Hospital, Kokomo 46901

Treasurer—Arvine G. Popplewell, 3530 S. Keystone, Indianapolis 46227

Assistant Treasurer—Joseph F. Ferrara, 111 S. Water St., Franklin 46131

Executive Committee—John W. Beeler, 1815 N. Capitol Ave., Indianapolis 46202, Chairman; Richard G. Ingram, 206 S. Main St., Montpelier 47359; Joe Dukes, Dugger 47848, Members

Speaker of the House—Lloyd L. Hill, 302 N. Duke St., Peru 46970

Vice Speaker—Lawrence E. Allen, 2009 Brown St., Anderson 46016

Executive Director—Mr. Donald F. Foy

TRUSTEES

District	Term Expires
1—John A. Bizal, Evansville	Oct. 1980
2—Paul W. Holtzman, Bloomington	Oct. 1978
3—Thomas A. Neathamer, Jeffersonville	Oct. 1979
4—Howard C. Jackson, Madison	Oct. 1980
5—Cleon M. Schauwecker, Greencastle	Oct. 1978
6—Davis W. Ellis, Rushville	Oct. 1979
7—Donald C. McCallum, Indianapolis	Oct. 1980
7—John G. Pantzer, Indianapolis	Oct. 1978
8—Jack M. Walker, Muncie	Oct. 1978
9—John A. Knote, Lafayette	Oct. 1979
10—Martin J. O'Neill, Valparaiso	Oct. 1980
11—Herbert C. Khalouf, Marion	Oct. 1978
12—Alvin J. Haley, Fort Wayne	Oct. 1979
13—Donald S. Chamberlain, South Bend	Oct. 1980

ALTERNATES

District	Term Expires
1—E. DeVerre Gourieux, Evansville	Oct. 1979
2—Edgar R. Cantwell, Vincennes	Oct. 1980
3—Richard G. Huber, Bedford	Oct. 1980
4—Mark M. Bevers, Seymour	Oct. 1979
5—William G. Bannon, Terre Haute	Oct. 1979
6—Dan W. Hibner, Richmond	Oct. 1981
7—J. E. Michael, Indianapolis	Oct. 1979
7—Gerald J. Kurlander, Indianapolis	Oct. 1979
8—Ted S. Doels, Middletown	Oct. 1979
9—Max N. Hoffman, Covington	Oct. 1980
10—Leonard W. Neal, Munster	Oct. 1978
11—Fred C. Poehler, La Fontaine	Oct. 1980
12—Franklin A. Bryan, Fort Wayne	Oct. 1980
13—John W. Luce, Michigan City	Oct. 1979

SECTION OFFICERS 1977-1978

Section on Surgery

Chairman—Jay L. Grosfeld, Indianapolis

Secretary—James A. Madura, Indianapolis

Section on Internal Medicine

President—Douglas H. White, Indianapolis

Secy-Treasurer—William Bastnagel, Indianapolis

Section on Family Practice

Chairman—Harvey Himelstein, Indianapolis

Secretary—Bernard J. Emkes, Indianapolis

Section on Neurological Surgery

Chairman—Louis W. Conway, Lafayette

Secretary—Daniel F. Cooper, Indianapolis

Section on Ophthalmology and Otolaryngology

Chairman—John Bizal, Evansville

Secretary—Daniel R. Evans, Valparaiso

Section on Anesthesiology

Chairman—Normand Townley, Indianapolis

Secretary—Wendell Edwards, Indianapolis

Section on Public Health and Preventive Medicine

Chairman—Ivan T. Lindgren, Aurora

Secretary—David J. Edwards, Indianapolis

Section on Radiology

Chairman—William J. Miller, Lafayette

Secretary—Wallace S. Tirman, South Bend

Section on Nervous and Mental Diseases

Chairman—Philip M. Morton, Indianapolis

Secretary—Jeffrey J. Kellams, Indianapolis

Section on Pathology and Forensic Medicine

Chairman—Robert Reed, Columbus

Secretary—David E. Smith, Indianapolis

Section on Pediatrics

Chairman—Robert Hannemann, Lafayette

Secretary—William C. Ashman, Fort Wayne

Section on Directors of Medical Education

Chairman—W. Thomas Spain, Evansville

Secretary—Robert Robinson, Indianapolis

Section on Cutaneous Medicine

Chairman—Edward Probst, Columbus

Secretary—Patrick Logan, Indianapolis

Section on Allergy

Chairman—Paul D. Isenberg, Indianapolis

Secretary—Beauford Spencer, Bloomington

Section on Urology

Chairman—Russell L. Judd, Indianapolis

Secretary—David Schlueter, Fort Wayne

Section on Orthopedic Surgery

Chairman—Robert F. Kimbrough, Fort Wayne

Secretary—Morris S. Friedman, South Bend

Section on Emergency Medicine

Chairman—David Gettle, Indianapolis

Secretary—Carolyn Cunningham, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1978:

Delegates: James A. Harshman, Kokomo; Malcolm O. Scamahorn, Pittsboro; Ross L. Egger, Daleville.

Alternates: George T. Lukemeyer, Indianapolis; Everett E. Bickers, Floyds Knobs; Gilbert M. Wilhelmus, Evansville.

Terms expire December 31, 1979:

Delegates: Patrick J. V. Corcoran, Evansville; Peter R. Petrich, Attica.

Alternates: Thomas C. Tyrrell, Hammond; Marvin E. Priddy, Fort Wayne.

DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place, Date of Meeting
1.	Forrest Radcliff, Evansville	William R. Wells, Princeton	May 17, 1979, Evansville
2.	Joe Dukes, Dugger	James P. Beck, Washington	1979, Sullivan
3.	Marvin McClain, Scottsburg	Charles X. McCalla, Paoli	Oct. 7-8, Scottsburg
4.	Brockton L. Weisenberger, Columbus	John I. Cooper, Madison	1979, Columbus
5.	J. B. Kho, Terre Haute	Clyde Jett, Seelyville	May 9, 1979, Terre Haute
6.	Hal R. Rhyneanson, Fortville	Douglas Morrell, Rushville	
7.	Stephen L. Hardin, Martinsville	M. O. Scamahorn, Pittsboro	May 23, 1979
8.	George A. Donnally, Geneva	Eugene M. Gillium, Portland	June 13, 1979
9.	Adrian Lanning, Noblesville	John A. Knote, Lafayette	June 14, 1979
10.	Lee H. Trachtenberg, Munster	Barron M. F. Palmer, Hammond	
11.	Amando L. Baluyot, Peru	Fred Poehler, La Fontaine	Sept. 20, Peru
12.	Thomas A. Felger, Fort Wayne	R. Wyatt Weaver, Angola	Sept. 7, Fort Wayne
13.	David L. Spalding, Mishawaka	Michael G. Quinn, South Bend	Sept. 13, South Bend

PHYSICIANS

General Practice Family Practice
Internal Medicine Radiology

Our JCAH accredited hospital is located in a scenic midwestern community, within one hour of a major metropolitan area. Practice opportunities are available to qualified physicians in the above listed specialties.

For further information, submit your Curriculum Vitae in strictest confidence or contact:

Director, Physician Relations

**MEDENCO
HOSPITALS Inc.**

P.O. Box 3448
Houston, Texas 77001

1-800-231-2855
(713) 621-8131 (within Texas)



"Efficiency is the key to your practice"

Graduates of P. C. I. are thoroughly trained in the most up-to-date methods as Medical Assistants (AMA accredited) and Medical Receptionists.

**PROFESSIONAL CAREERS
INSTITUTE**

6321 La Pas Trail, Indianapolis, IN 46268
Telephone: (317) 299-6001

ADVERTISERS IN THIS ISSUE

September 1978	Vol. 71	No. 9
Blue Cross-Blue Shield		803
Bristol Laboratories	845,	846
Brown Pharmaceutical Co., Inc.		828
Burroughs Wellcome Co.		812
Dave Waite Leasing		822
Flesher, Realtor		860
General Microcomputer		850
Hanger Prostheses		858
Import Motors, Inc.		805
Indiana Medical Bureau		855
Lilly, Eli and Company, Inc.		851
McClain Car Leasing, Inc.		856
Marion County Medical Society		806
Mead Johnson Laboratories	829,	830
Medenco Hospitals, Inc.		942
Medical Protective Company		859
Morris Plan		845
P&SLI		815
Pennwalt Corp.	852,	853
Professional Careers Institute		942
Purepac Pharmaceutical Co.		842
Richardson-Merrell		811
Roche Laboratories	Covers,	801, 809
Rockwood Insurance Company		823
Smith, Kline & French	810,	824-825
The Pointe		848
The Upjohn Company		854
Townsend, J. Russell and Associates		862
U.S. Air Force		821
U.S. Navy		843
Yellow Medi-Car		857

In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

October 1978 • Vol. 71 • No. 10

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

U. OF CALIFORNIA, SAN FRANCISCO, CA 94143



LIBRARY
U.C. SAN FRANCISCO
NOV 1 1978

THE MESSAGE OF TENSION

HEADACHES
SWEATS
TENSE, TAUT MUSCLES
HYPERVENTILATION
TACHYCARDIA
PALPITATIONS
BURNING IN STOMACH
FULLNESS
FREQUENCY

to relieve psychic tension
and its functional symptoms

VALIUM®
(diazepam) 

2-mg, 5-mg, 10-mg scored tablets

VALIUM® (diazepam)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia,

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

The people of Indiana owe a debt of gratitude to Dr. William Lomax. His generosity made possible the construction of the building that became the Indiana University School of Medicine from 1908 to 1918. Later it was used by the Indiana State Board of Health, and by the Indiana State Highway Commission, until it was razed in 1961.

Dr. Lomax, whose generous contribution facilitated the development of Indiana University School of Medicine during its early years, died before the school was conceived. Born in Guilford County, North Carolina, March 15, 1813, he moved with his parents in 1817 to Wayne County, Indiana. Reared as a farmer, he began the study of medicine at the age of 21, in the office of Dr. Joell Boggs. In 1836 Dr. Lomax attended lectures at the Medical College of Ohio at Cincinnati. He then moved to Marion, Indiana in 1837, where he practiced for several years in the office of Dr. John Foster.

In 1847, and again in 1848, Dr. Lomax attended the series of lectures at the Indiana Medical College at LaPorte, where he received his M.D. degree.



Dr. William Lomax

At the onset of the Civil War, Dr. Lomax was the first surgeon to be commissioned by Governor Morton. Dr. Lomax served as medical director of the 15th Army Corps.

He was a founder of the Grant County Medical Society, and of the Indiana State Medical Society, being president in 1856. He was appointed a member of the first State Board

of Health in Indiana and served as its president for four years.

This column is primarily concerned with Dr. Lomax's role with medical education in Indiana. He served for a brief time as professor of surgery in the Fort Wayne Medical College (The Journal, 69:822, 1976). He served as member and president of the Board of Trustees of the Medical College of Indiana, being an early and ardent advocate of requiring more adequate premedical education for the medical student.

Dr. Lomax died April 27, 1893, at his home in Marion. He left a bequest of approximately \$75,000, this being used in 1895 to erect the first structure in the state specifically designed to be a medical school. This building, located across the street from the State House in Indianapolis, was featured on the October, 1973 cover of The Journal and in this column in the June 1977 issue of The Journal.

Unlike most medical schools in the country, Indiana University School of Medicine was favorably reported in the Flexnor Report of 1910. This building and its laboratories undoubtedly played a significant role in this achievement.

The I.U. Physician: 1903-1978

75 Years of Medical Education in Indiana

SEE PAGES 968-970

WHAT'S NEW?

Stuart Pharmaceuticals announces the introduction of KASOFTTM, (dioctyl potassium sulfosuccinate, 240 mg.) a new high-strength stool softener especially formulated for those with severe constipation and anorectal disorders.

* * *

Amko has a new all-stainless steel Laufe mini-laparotomy retractor that is self-adjusting and self-retaining, requiring only one hand to operate. It offers increased visibility and convenience. Two sizes: standard blade 1" X 1 1/2" and 1 1/2" X 2 1/2".

* * *

Stuart Pharmaceuticals is announcing a new, low sodium formulation for Mylanta[®] and Mylanta[®]-II (aluminum and magnesium hydroxides with simethicone). Especially indicated for patients on salt restricted diets.

* * *

Upjohn is able to perform two different tests to determine blood level of parathyroid hormone (PTH) in its Laboratory Procedures Esoteric Center. PTH in the body divides in various proportions into intact PTH and an inactive C-terminal fragment. The Upjohn Laboratory performs the test for intact PTH first, saves the blood specimen and later does the inactive fragment test if the physician, on further investigation, finds that both tests are necessary. Either one of the tests may be requested for the initial determination.

* * *

Marion Laboratories announces the Bio-BagTM Environmental Chamber-Type C as a disposable system designed to generate and maintain a CO₂ enriched environment for transport of organisms that require an atmosphere of CO₂. The CO₂ Bio-Bag may be placed in an incubator, and the growth may be viewed through the bag.

* * *

Micropore brand Surgical Tape, made by 3M, is packaged in disposable dispensers to keep the tape clean and usable and to minimize cross contamination. The tape, which is porous and hypoallergenic, comes in 13 different widths, lengths and styles, and in white or skin-tone.

* * *

Norwich-Eaton has announced that the medical libraries of hospitals have been supplied with a much needed book, "Enteral Hyperalimentation with Chemically Defined Elemental Diets: A Source Book." It lists a bibliography of more than 350 articles on the subject. It gives access to information about enteral hyperalimentation quickly and accurately.

* * *

Radiation Monitoring Devices has announced the development and production of a small, highly sensitive probe system for detecting radiation in wounds caused by nuclear accidents. The probe functions when attached to a standard counter or pulse height analyzer. Both are expensive and need not be included in standard operative kits.

Upjohn is introducing Florone, a new high potency prescription drug effective against a wide variety of noninfectious inflammatory skin disorders. Florone is available in cream or ointment form, and is formulated without the potentially irritating parabens, a kind of preservative.

* * *

The 3M Company has a Cold/Hot Pack that is good for both therapeutic purposes. It may be heated in hot tap water or cooled in the fridge. It is soft and flexible and is filled with a gell-like material. It is reusable. It was formerly marketed as the Cryogel Cold Pack.

* * *

Andover Medical has a low impedance, low offset, self-retaining limb clip designed for resting ECG procedures. It eliminates the need for rubber straps and separate electrodes. The AMI KLIP 2000-200 can be used on adults or children.

* * *

Hewlett Packard announces a new portable three-channel automatic cardiograph, which operates on a rechargeable battery and can be conveniently used away from power outlets. As many as 30 electrocardiograms of 60-second duration may be taken before recharging is required. The battery charger, supplied with the instrument, provides a full charge in two hours. However, the battery becomes functional again after only two minutes of recharging.

* * *

A. H. Robins is expanding its Phenaphen[®] group of analgesics with the introduction of Phenaphen-650 with codeine. This is a Class III controlled drug, offered for the relief of mild to moderate pain. Each tablet will contain 30 mg of codeine phosphate, USP, and 650 mg of acetaminophen, USP.

* * *

The Dade Division of the American Hospital Supply Corporation is introducing a test that will help to more quickly diagnose coronary thrombosis. CardiozymeTM CK-MB identifies the presence of the "MB" isoenzyme, which is normally present in the case of heart damage. The test may be read within 15 minutes and is simpler to perform than other tests.

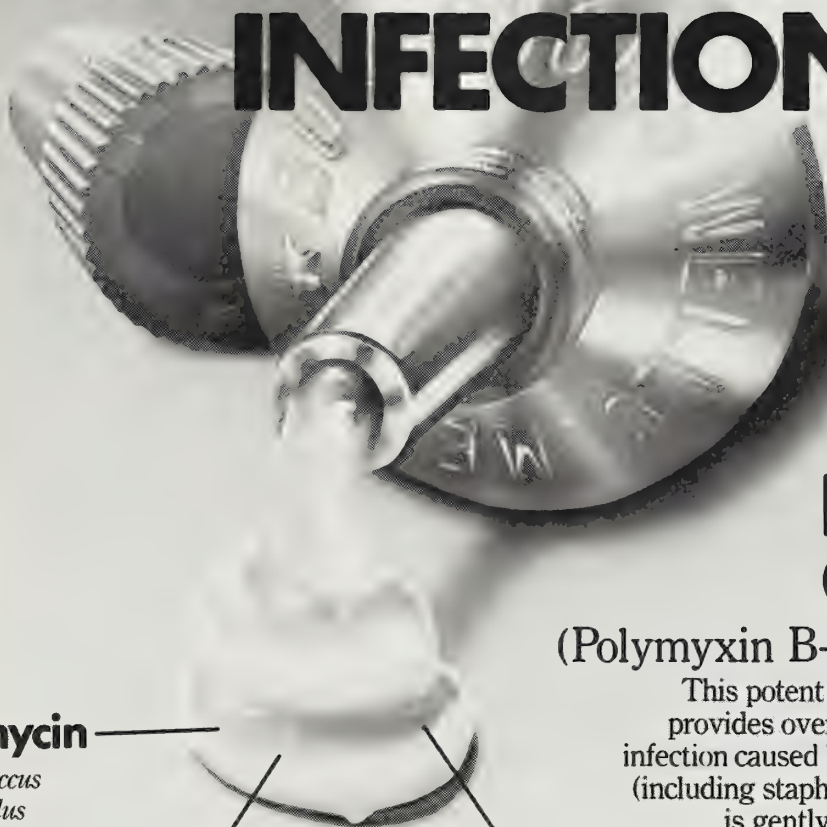
* * *

Parke-Davis has announced a Shave Prep Tray. The styrene tray has two deep compartments for washing and rinsing. The tray contains a Schick Disposable Razor, a sponge impregnated with lanolin-based soap, two cotton-tipped applicators, a linen protector to protect the bed from spills and two large absorbent towels.

CONTINUED ON PAGE 950

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin[®] Ointment (polymyxin B-bacitracin-neomycin).



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Contents

SCIENTIFIC ARTICLES

- 983 **Depression in the Elderly**
Susanne Blix, M.D.
(Tenth Continuing Medical Education article)
- 990 **Raynaud's Phenomenon**
Jack R. Adair, M.D.
- 994 **Legionnaire's Disease**
Wei-Ping Loh, M.D.
- 997 **The Fountain of Youth**
George S. Porter, M.D.
- 1000 **CME Pre-Test**

EDITORIALS

- 948 **Editorial Notes**
- 953 **Cost Containment: Where the Monkey Is**
- 954 **The Poor—and the Poor Taxpayer**
- 956 **Present for Duty, Sir!**

SPECIAL FEATURES

- 964 **Emergency Medical Technicians**
- 966 **Second Consultations**
- 968 **The I.U. Physician: 1903-1978**
- 978 **That Certain Sparkle—James M. Pfeifer, M.D.**
- 1004 **The Scalpel and the Pen**

DEPARTMENTS, MISCELLANEOUS

- 943 **Museum Notes—Charles A. Bonsett, M.D.**
- 944 **What's New?**
- 958 **Letters**
- 975 **Tax Tips—Lawrence A. Jegen III, J.D.**
- 980 **Cancer Corner—William M. Dugan, Jr., M.D.**
- 1002 **British Browsings—Duke H. Baker, M.D.**
- 1008 **Book Reviews**
- 1010 **Future File**
- 1012 **From The Journal 50 Years Ago**
- 1012 **There's a Word for It—Richard J. Noveroske, M.D.**
- 1013 **News Notes**
- 1020 **Obituaries**

ABOUT THE COVER

This never-before-published Bass Photo shows the first of four buildings that have been architectural symbols of the I.U. School of Medicine. It is the only photo featuring an entrance sign that reads "Indiana University School of Medicine." The Indianapolis structure was first occupied in 1903 by the Central College of Physicians and Surgeons. Later it became the state medical school; today, the location is a parking lot.



EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue.

Representative for national advertising is the State Medical Journal Advertising Bureau, 711 South Blvd., Oak Park, Ill. 60302.

Annual subscription rates: ISMA members, \$8, included in annual membership dues; ISMA senior members, \$10; Libraries, \$12; all others, \$14. Additional postage: Canada and PUAS countries, \$2; Foreign, \$3. Subscriptions are renewable in July and January.

Entered as second class matter January 25, 1933, at the Post-office at Indianapolis, Indiana.

THE JOURNAL of the Indiana State Medical Association (USPS 284-440) is published monthly by the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208. Second-class postage paid at Indianapolis, Ind., and at additional mailing office. No copyright is claimed.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

Our International Standard Serial Number is ISSN 0019-6770.

Indexed in Index Medicus and Hospital Literature Index.



COMPUTER?

BEFORE YOU MAKE A DECISION
TALK TO A SPECIALIST.

GENERAL MICROCOMPUTER

COST EFFECTIVE
MICROCOMPUTER SYSTEMS
TAILORED TO THE SPECIFIC
NEEDS OF YOUR PRACTICE

GENERAL MICROCOMPUTER, INC.
1657 COMMERCE DRIVE
SOUTH BEND, INDIANA 46628
(219)-233-9171

EDITORIALS

Editorial Notes . . .

Interest in the early diagnosis of hypothyroidism in newborns and in its prompt treatment is justified by the clinical observation that at least one breast fed baby showed no signs of thyroid abnormality until weaning. Thyroid hormone levels in breast milk are significantly higher than in either cow's milk or commercial formulas.

SRI International, a nonprofit organization that performs contract research, is developing an ultrasonic camera. It makes images that are similar to x-rays, both still and in motion. It has the advantage of not using ionizing rays and also promises to produce better images in soft tissue detail. Early work indicates special adaptation to study of tendons and muscles, for screening newborns for hip dislocations, for viewing abdominal organs and blood clots in the legs, and as a screen for breast cancer.

"Community health education programs are one of the most viable methods to help alleviate problems such as the high cost of medical care, the overutilization and incorrect use of medical facilities, money wasted on quackery and practices that are detrimental to the health." The American Academy of Pediatrics Committee on School Health recommends more and better health education in elementary and secondary schools and in teachers' training programs.

Senator Ted Kennedy is quoted as saying that "We believe we can gain passage one time." He was speaking of his NHI bill. He thinks that a phased-in program, which would require Congressional approval on several

occasions, would not have a chance. This is good news. Kennedy knows that, if the public becomes acquainted with NHI gradually, the chances are that it will become unpopular and will be defeated between phase-ins.

Scald burns are the most common type of thermal injury in children. Up to 17% of scald burns are caused by tap water and are severe enough to require hospitalization. Household water temperatures should never be above 125°F, but many household hot water supplies are. Water above 130°F will cause severe burns within 30 seconds. The American Academy of Pediatrics advises careful regulation of hot water heaters. 120°F is hot enough for anybody.

The American Diabetes Association has concluded that there is little justification for regulation of use of saccharin. Diabetic patients are probably the most carefully treated group of patients in modern times. They also have probably ingested the most saccharin of any identifiable group of patients. If saccharin is carcinogenic, it would seem inevitable that clinicians would have realized this as a fact long ago. The ADA cautiously states that it encourages further animal studies.

Exposure to PCBs (polychlorinated biphenyls) should almost never interfere with breastfeeding, according to the American Academy of Pediatric's Committee on Environmental Hazards. "There are no known effects in children at levels found in people in the United States." Women who have a history of exposure to PCBs would be the only exception.

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 3935 N. Meridian Street, Indianapolis 46208.

Consulting Editors: A. W. Cavins, M.D., R.R. 25, Box 172, Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1, Box 202, Gaston 47342; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne 46802; I. W. Wilkens, M.D., 4820 E. Pleasant Run Pkwy., N. Dr., Indianapolis 46201; W. D. Snively, Jr., M.D., R.R. 1, Box 227, Evansville 47712; Charles A. Bonsett, M.D., 6133 E. 54th Place, Indianapolis 46226.

Editorial Board:

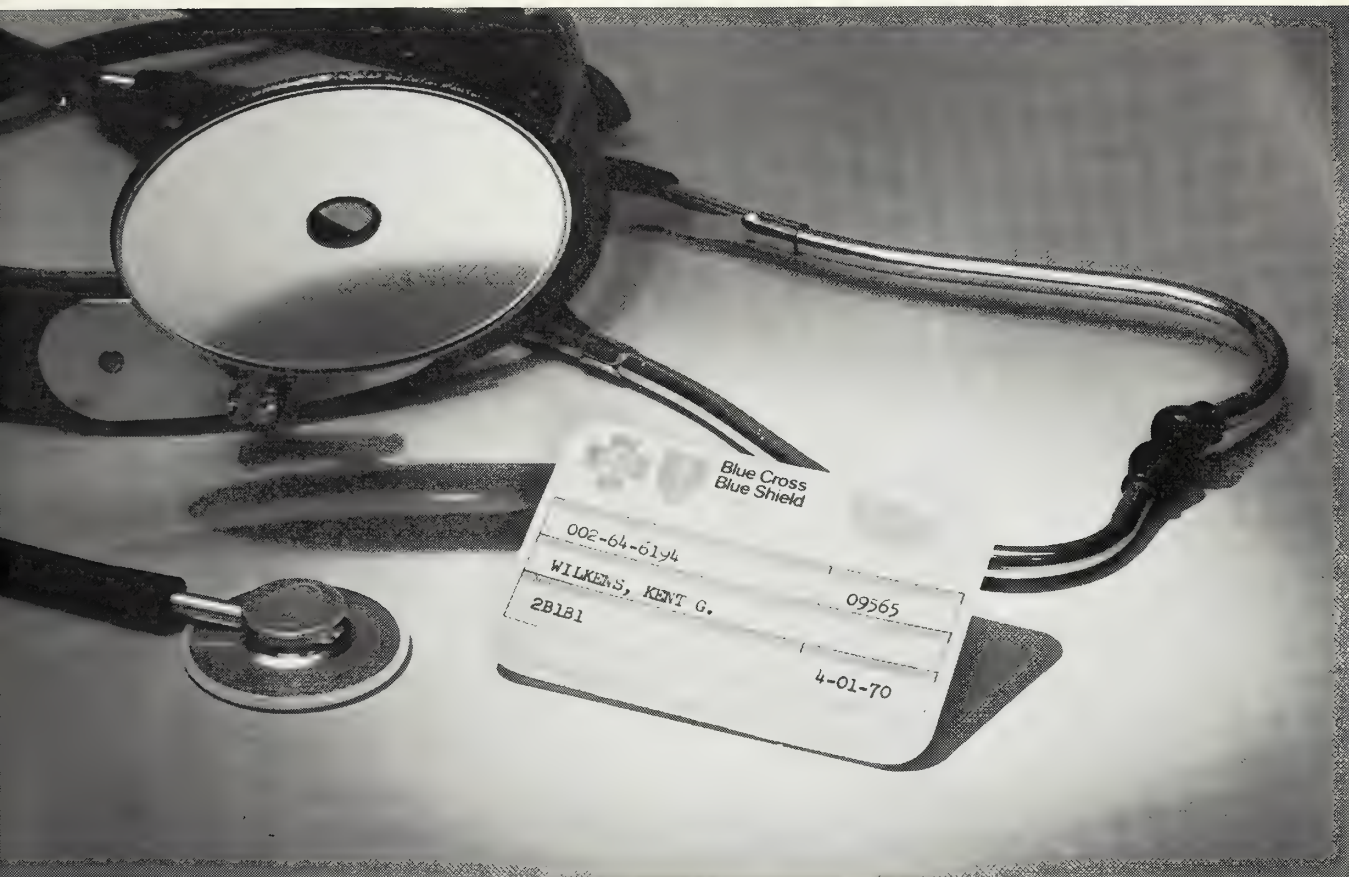
	Term Expires
Steven C. Beering, M.D., Indianapolis	Dec. 31, 1978
Paul S. Rhoads, M.D., Richmond	Dec. 31, 1978
Elton Heaton, M.D., Madison	Dec. 31, 1979
Rodney A. Mannion, M.D., La Porte	Dec. 31, 1979
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1980
Wei-Ping Loh, M.D., Gary	Dec. 31, 1980

Business Manager: Donald F. Foy

3935 N. Meridian, Indianapolis, Ind. 46208

Managing Editor: Martin T. Badger

Take advantage of a great association!



Get these special benefits – available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage – and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association – entitling you to special group rates for these benefits:

- One full year in-hospital care
- 100% semi-private room and hospital extras
- Allowances for surgery, anesthesia, obstetrics, medical visits, diagnostic and radiation therapy
- \$250,000 Major Medical Benefits

That's not all. You also benefit from the immediate recognition and automatic acceptance of the Blue Cross and Blue Shield membership card. The special rates available through the Indiana State Medical Association membership make this coverage your best investment in personal protection. You can get it – now.

Call or write: Mrs. Kathryn Eads,
Professional Accounts, Blue Cross and Blue
Shield of Indiana, 120 W. Market Street,
Indianapolis, Indiana 46204. Telephone: (317)
263-4925.

120 West Market St.
Indianapolis, Ind. 46204

© Reg. Mark Blue Cross Assn.
* Reg. Serv. Mark. Nat'l Assn.
of Blue Shield Plans



**Blue Cross
Blue Shield**
of Indiana

WHAT'S NEW?

CONTINUED FROM PAGE 944

Du Pont is introducing a new clinical analyzer, 'aca' III. The third generation Automatic Clinical Analyzer automates all 35 tests currently available, has 24-hour availability, fast results, positive sample and test identification and random sample processing. Its integrated computer has a vocabulary of 32,000 words. It may be programmed to display results and to print hard copy in any one of three other languages besides English.

* * *

In Books...

Anchor Press announces "People of the Lake: Mankind and Its Beginnings" by Richard E. Leakey and Roger Lewin. It is an account of how our ancestors lived as gather-hunters for fully 2 1/2 million years before the emergence of modern man. 298 pages, 34 photographs, 2 linecuts, \$10.95.

* * *

The second edition of "Emergency Medical Services" is now available from the National Fire Protection Association in Boston. The author, James O. Page, one of the nation's authorities on police and fire department emergency medical services, has revised the book to include all the latest information available on the subject. 432 pages—\$8.75.

* * *

"The Accident Book" has been produced in cooperation with the American College of Emergency Physicians to instruct people to stop to assist victims of automobile accidents. The booklet is the 15th of a series of Answer Books produced by the Shell Oil Company. It may be obtained without cost at most Shell service stations.

* * *

Ballantine Books is releasing "Woman Doctor." It is written by Florence Haseltine, M.D. and Yvonne Yaw to provide a study of difficulties encountered by a woman intern in a medical world dominated by men. \$2.25.

* * *

Dell Books announces "Stop Running Scared!" a paperback by Herbert Fensterheim, Ph.D., and Jean Baer for which the sub-title is "Fear Control Training: How to Conquer Your Fears, Phobias and Anxieties." The authors wrote the bestseller, "Don't Say Yes When You Want to Say No." \$2.25.

* * *

Anchor Press has released "The New Old," a collection of writings by experts on the subject of aging. The subtitle is "Struggling for Decent Aging." Peter Oppenheimer, director of the Institute of Study for Older Adults, classifies it as "the finest collection on aging that I have ever read." 510 pages—\$5.95.

* * *

Dell Books is publishing a book, "Easy Running," an illustrated guide to the sport of the 70's. An estimated 20 million Americans now run or jog—this book provides everything one needs to know to start and keep a healthy and satisfying running program. The publication will receive adequate advertising—the initial print order is for 300,000 copies.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Products Inc.
Manati, Puerto Rico 00701



In treating certain G.I. disorders...

Enhance your therapeutic expectations
with the triple benefits of

Adjunctive
Librax

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antisecretory/antispasmodic

Librax is unique among G.I. medications
in providing the specific antianxiety action of
LIBRIUM® (chlordiazepoxide HCl) as well as the potent
antisecretory and antispasmodic actions of
QUARZAN® (clidinium Br) for adjunctive therapy
of irritable bowel syndrome* and duodenal ulcer.*

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

In pharyngitis and tonsillitis

...prompt temporary relief
of pain even before
patients leave
your office.

CĒPASTAT[®]

mouthwash/gargle/sore
throat lozenges

Merrell

Proven Anesthetic Effectiveness

Spraying the throat with CĒPASTAT brings soothing relief within minutes. Your patients will appreciate this relief while waiting for therapeutic measures to take hold. The well-established anesthetic effects of CĒPASTAT provide soothing temporary anesthesia to the irritated or inflamed oropharyngeal mucosa.

CĒPASTAT in your treatment room . . .

Used as a spray, CĒPASTAT is more likely to deliver the most relief to the painful area of the throat.

Suit the product to the patient . . .

The liquid is best for use at home as a spray or gargle. Lozenges are ideal for patients on the go.

A recommendation is best . . .

It costs less. Keeps the emphasis where you want it . . . on more important counter-measures — your prescription for anti-infectives, for example.

MERRELL NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



relief of minor
sore throat when
patients want it

stat

Cost Containment: Where the Monkey Is

GEORGE C. MANNING, M.D.
Fort Wayne

Memories are short, and there are few who remember the propaganda that brought "socialized" medicine to America with the Medicare-Medicaid bill: "—So that all our elderly and our poor may have all the medical care they need without the stigma of having to accept charity!"

Memories are also short in that there are few who remember that all knowledgeable persons predicted that the result would be an astronomical increase in cost with essentially no improvement in what was an already nearly optimal *system* of medical care.

It should also be remembered that politicians and bureaucrats are completely incapable of comprehending the *system* of medical care to the point where it has been called a "non-system," and unfortunately many physicians, including those at the sociopolitical interface with the public, even though they were brought up and live in the system, are unable to describe it verbally.

The problem is that the politicians have tried to impose a bureaucratic system of organization upon medicine, at a fantastic cost to the country, and—as was fully predictable—to no avail for the simple reason that apples and oranges cannot be hybridized.

The problem could be solved if Medicine would simply reorganize along bureaucratic lines (a statement which I hope will never be used out of the context of this paragraph). Unfortunately there *are* things that are impossible, and this is one of them. The reason it is impossible is that Medicine deals with what scientists call "a non-linear system." A non-linear system is, in brief, a system in which there are so many variables interacting with so many variables that *absolute* predictions are never possible. Statistical *probabilities* exist, but whereas the politician is quite happy dealing with occurrence-probabilities in total populations, the physician does not have this comfortable cop-out when he is dealing with *the* person, because *the* person has the right to expect that he will be treated as if he were (as he is) unique, and that he will receive the best prediction on the basis of the interaction of known and dis-

coverable variables with which the physician's knowledge and intelligence can provide him.

Science in effect discloses an ever-increasing, but always finite, number of variables in the interactions of the human body with itself and with the environment (used in its broadest sense). Although Science can *count* facts, it can do very little to codify them in more than a gross (and variable) manner into groups with indistinct borders and overlapping boundaries.

Strict codification is the essence of bureaucracy, and when it is not possible, a bureaucratic system cannot exist, or if attempted, function. It is because politicians are blind to this fact, and because they think more money will solve everything, that they have escalated the costs of attempted control of medical care beyond anything that is reasonable. There is only one way to control these costs, and that is to *force* bureaucracy on medical practice, a move which has already diminished the quality of the system's application to innumerable individual patients.

If our bureaucratic government were truly interested in "cost containment" as it applies to medical care, it could be immediately effected by getting government out of Medicine. The net effect on Medicine would be an increase in the quality of medical care to patients. Unfortunately, "cost containment" is a smoke screen to hide the fact that the real motivation of government is not "more medicine at less cost," but is instead Jobs for Bureaucrats; bureaucrats whose wages are paid by taxpayers, and the taxpayers are getting pretty unhappy.

The elaborate system of ineffective "safeguards" which bureaucracy imposes on Medicine is totally unnecessary. Where systems exist there will be those who attempt and do beat it. But all-in-all physicians have too many other things to think about to *try* to "beat the system." If ever proof of this was wanted, simply look at the record of Medicaid fraud investigations. Who have they turned up? Chiropractors, laboratories (usually not physician-operated), pharmacists, and hospital and nursing home administrators.

But the increasing cost and decreasing quality of medical care is here to stay because that is the will of the government, and what is anyone going to do to change it?

Reprinted with permission of the author and of THE BULLETIN, published by the Fort Wayne Medical Society, where the editorial appeared in July 1978.

The Poor—and the Poor Taxpayer

L. A. ARATA, M.D.
Shelbyville

It would indeed be good and helpful if the politicians and sociologists discarded the use of the word *poor* and substituted the word *unfortunate*, for then we might begin to get some straight thinking about the place for public (taxpayer) aid that could be helpful to the recipients.

There are several categories of people included in the present concept of "helping the poor." I suggest that we consider that "the unfortunates" may be *poor*, *needy* or *careless*, or a combination of these. Many of the poor are not needy; many of the needy are not poor; many of the careless are both needy and poor; many of the careless are neither needy nor poor. There are other possible permutations and combinations of these categories, and undoubtedly all are represented by large numbers of people. Finally, there is the *poor taxpayer*, from whom all benefits are extracted.

Few of us question the humanity of helping the needy. Most who read this essay are taxpayers, and the taxpayer should have some right to a fair share of his earnings. Most of us realize that many of "the careless" cannot be helped by our present social assistance programs. Why should the poor taxpayer be expected to provide good housing to the careless who convert it into a slum shambles in a year or two? Or to provide money for food

and clothing, only to have the money diverted to alcohol, drugs and color TV sets? Or to pay for Medicaid Nursing Home care for the elderly person who has given his home and savings to his own children or friends in order to qualify for Medicaid-paid care?

Since first claim on the incomes of all taxpayers is exercised by government—our share is what the politicians tell us we may retain—it seems that it should be the duty of that same government to assure that the taxation money is spent well and wisely for those in need. The record of the past 40 years demonstrates that government cannot do this. In fact, I wonder whether as many as 1% of the recipients of government (taxpayer) aid have really and truly been helped by the programs.

It is my belief that the largest numbers of people aided by any and all government programs are the politicians who buy votes with taxpayer money, and the high salaried political and bureaucratic administrators who draw their salaries administering the programs.

I hope that all of us continually remind our politicians that, somewhere in the infinity of "aid programs," one be constructed to aid the *poor taxpayer*.

FOR SALE

ALBANY, INDIANA—Retiring medical doctor's residence and office. Established 50-year general practice. Located in town of 2,500 population with growing community. Situated within 12 miles of all modern hospital. A beautiful 2-story home with 9 rooms, fully carpeted down with hardwood floors up. Formal dining room, family room, living room, kitchen with glassed in breakfast room, 2 ceramic baths, all nicely decorated. Full basement with doctor's office, 3 finished rooms with separate entrance and garage. Gas heat with central air. Also a 2-car garage with electric opener. Nice fenced in yard with trees. TOM D. FLESHER, REALTOR—205 West State Street, Albany, Indiana 47320. Phone (317) 789-6162.



Your Patient Saves Dollars with Generics by PUREPAC

Here's Proof!

These products and prices were taken directly
from newspaper advertising by various retail pharmacies.

QUANTITY	BRAND NAME®	PRICE	PUREPAC GENERIC	PRICE	SAVINGS
30	Polycillin (250 mg.)	\$8.70	Ampicillin (250 mg.)	\$2.40	\$6.30
100	Equanil (400 mg.) ©	8.09	Meproamate (100 mg.) ©	1.83	6.26
100	Darvon Comp. 65 ©	7.83	Propoxyphene HCl Comp. 65 ©	4.63	3.20
100	Pavabid (150 mg.)	11.73	Papaverine HCl T.R. (100 mg.)	4.33	7.40
100	Thorazine (50 mg.)	6.03	Chlorpromazine HCl (50 mg.)	3.23	2.80
100	Librium (10 mg.) ©	7.11	Chlordiazepoxide HCl (10 mg.) ©	4.89	2.22

The savings add up! So, when you prescribe generics, specify Purepac,
the largest generic manufacturer in America.

Brand names are registered trademarks of
Bristol Labs., Wyeth Labs., Eli Lilly & Co.,
Marion Labs., Smith Kline & French Labs.,
Roche Labs. respectively.

 **PUREPAC**

Elizabeth, NJ 07207

AMERICA'S LEADING NATIONAL BRAND OF GENERICS

Guest Editorial

Present for Duty, Sir!

MARK R. JOHNSON, M.D.
Oklahoma City, Oklahoma

I think this CME thing is just a terrific idea. Continuing medical education. Wow! Whoever thought up the idea of that tricky acronym—CME—is a genius. And the guys who decided to assign CME credits to certain approved get-togethers are simply brilliant. But the real wizards of this super-sell are the fellows who decided to compel themselves—and us less enlightened followers—to earn so many credits a year—or so many credits every two or three years—or *else*.

Altogether, an epochal achievement.

In a few sparkling strokes the future has brightened for unheard-of travel agencies, second-rate hotels, aging resorts and run-down convention halls; for academicians who've lost their grants, their stature or their tenure; for teachers who can't teach, speakers who can't speak and researchers who don't research.

As I understand it, those of us who practice medicine will have a whole batch of CME programs from which to choose. The brochures I've received to date offer courses in the desert in July and August, in Chicago in January and February, in the subtropics in the summer and in the Carribean during the hurricane season. We can select three-day, two-day, five-day, week-day or weekend courses of instruction. And some of them offer wonderful opportunities to combine family vacations while we earn our CME credits: We get up early—a really great vacation idea—attend classes all morning and then have the rest of the day to enjoy our families.

Of course these stimulating refresher courses aren't free but they are—probably—partially at least—I think—tax deductible. They cost from fifty to four-hundred-fifty dollars, plus the thirty to fifty dollars a day for bed and board, plus

thirty to five-hundred dollars for transportation. And all or a lot of this expense is tax deductible, along with the two-hundred to fifteen-hundred dollars it will cost you to keep your office functioning while you're gone. The two-hundred to two-thousand dollars you won't earn while you learn is not deductible but since you don't make it you don't have to pay taxes on it anyway.

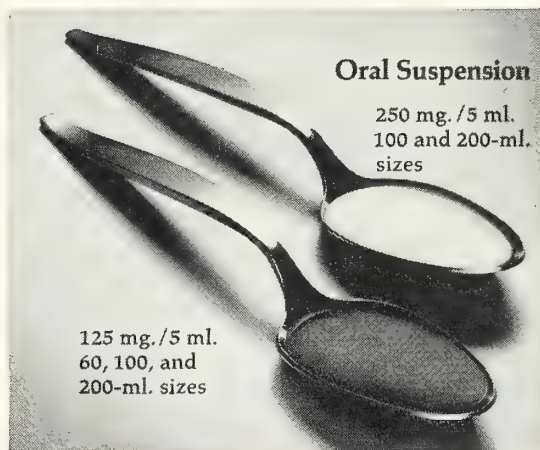
You'll be seeing fewer patients and your annual expenses will be greater so you'll be forced to raise your fees but you'll be better informed, mentally and physically refreshed and therefore, more efficient—until you try to catch up with the mail, the charts, the phone calls, the bills and the insurance forms that have piled up during your absence. But don't despair—you'll be more competent—really up to date—in treating all your patients with lupus erythematosus, histoplasmosis, dermatomyositis, equine encephalitis, malignant melanoma and cancer of the stomach. You will have learned a lot about the right way to practice medicine from a lot of people who have never practiced medicine but who knew exactly what you needed to know. You didn't realize that you couldn't learn, couldn't read journals or books, couldn't increase your knowledge and competence while you were actively engaged in the practice of medicine. And you damn sure can't earn your mandatory CME credits if you're so busy taking care of patients.

I'm not really opposed to education—even continuing medical education and, I'll admit, I've exaggerated my objections to compulsory CME. But I resent being told how and when and what I am to learn. I am convinced that the only real credits I can earn will come from my patients and their welfare will be the only real measure of my competence.

I didn't mind answering roll call when I was in grade school or in the Army. But then I *knew* I wasn't a free man.

Reprinted with permission of the author, editor of the Journal of the Oklahoma State Medical Association, in which this editorial appeared in April 1978.

easy to take



Keflex®
cephalexin



500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

LETTERS

With this issue, THE JOURNAL introduces what is hoped will become a standing feature of the magazine. Letters will be published as space permits and at the discretion of the editor. They will be subject to editing. Reader response is the heartbeat of a publication—it provides the feedback necessary in affecting changes. Why not share your thoughts with other members of the Indiana State Medical Association?

Journal Column Draws Fire

To the Editor:

I am not sure of the propriety of a Consulting Editor writing a "Letter to the Editor" of his own publication, but I am doing so, regardless. In the August 1978 issue, on page 746, Dr. R. J. Noveroske, in his column "There's a Word for It," takes the rest of us physicians to task for misuse of the word *pathology*. He illustrates his point by the oft used question, "Is there any pathology?" He states, "It is inaccurate to ask if there is pathology or 'a study of disease' present, when our question really is, 'Is there disease present?'"

Here, I beg to differ. "Is there any pathology?" really means "Is there any condition in an organ or body fluid which has been produced by disease?" Doctors who use the word *pathology* with this intent are entirely within their rights and are using correct English.

The definition in Webster's Collegiate English Dictionary gives *two* uses of the word *pathology*: "1. The science treating of diseases, their nature, causes, etc. 2. The condition, as of an organ or fluid, produced by disease." The Oxford English Dictionary concurs and labels the second meaning as a "transferred sense."

I enjoy Dr. Noveroske's column, as a rule, but I do think he is a bit inaccurate himself in this instance. Doctors suffer enough frustration without having one of their pet words declared off limits, unjustly.

A. W. CAVINS, M.D.
Terre Haute

To the Editor:

Dr. Noveroske describes *ultrasound* as "just another part of the electromagnetic spectrum . . ." in his column "There's a Word for it," page 705, July 1978.

That statement is erroneous. *Ultrasound* is sound (mechanical energy) of any frequency above the audible range. Medical diagnostic ultrasound is usually employed with a frequency of 1.0 to 10.0 megahertz. Film badges and lead aprons are not necessary for personnel in ultrasound labs, since there is no potential for ionizing radiation from such diagnostic machines.

JONATHAN T. STAFFORD, M.D.
Bloomington

Like a trip to New England

FAMOUS CRUTCHER INDIANAPOLIS ANTIQUE SHOW

October 27, 28, 29, 30

State Fairgrounds

1500 E. 38th (U.S. 36)

INVESTMENT QUALITY

144 dealers - many from east

Free parking ADM. \$2-4 days

11 A.M. - 10:00 P.M.

Sunday 12 to 5 P.M.

**Quality CONTROLLED
EVERYTHING GUARANTEED**

Many national dealers

**No other Indiana show
compares in any way!**

**JEAN CRUTCHER,
7370 Old Natl. Tr., E., New Carlisle, Ohio**

I think Dr. Cavins has a point. When I hear the word *pathology* used in the kind of context I described in the essay, I find it irritating—I particularly did when I heard it used by a pompous physician a night or two before I wrote the first draft of that essay. Maybe I transferred my irritation toward him to the term, and I may not be fair to the other people who use it because of its derived or transferred sense . . .

* * *

I don't think Doctor Stafford understands that the term electro-magnetic spectrum includes the whole of the waves that are spread by simultaneous periodic variations of electric and magnetic field intensity.

My Third International Unabridged Merriam-Webster Dictionary puts radio waves at the long end of the wave length spectrum in its definition. This appears to be a restricted definition to me, for it wouldn't include our common electric alternating current that vibrates at 60 cycles per second nor speech—from a few cycles per second in the bass range to about 8,000 cps or so. Most people think electricity and speech are part of the electromagnetic spectrum; cathode ray tubes display A.C. current and the spoken voice in convincing demonstrations.

But anyway, medical ultrasound with frequencies of 1.0 to 10.0 megahertz are shorter in wave length than radio waves; the common A.M. radio stations go down

LETTERS

to 550 kilohertz. So Merriam-Webster would include ultrasound in its electromagnetic wave definition.

If Doctor Stafford wants to think of ultrasound as sound or mechanical energy, that's all right with me. But these waves can also be thought of as radiation, and there's no need for a new medical specialty name, such as diagnostic imaging, insofar as science is concerned, just because there is a new modality of using radiation.

RICHARD J. NOVEROSKE, M.D.
Evansville

Thumbs Up for CME Articles

To the Editor:

I just wanted to tell you how much I appreciate the continuing medical education articles in THE JOURNAL. This is certainly an excellent way to obtain Category 1 postgraduate education credits. I look forward to each issue!

I am particularly proud of this month's journal

(August 1978). The two articles which give credit are well written.

I have told several of my colleagues about this. Apparently, they had not been looking at THE JOURNAL very closely. They have all told me now that they are going to pay more attention to it.

I have figured that in order for me to obtain Category 1 credit it costs me about \$100 an hour when I consider the cost of closing my office, travel, food and lodging, and the like. Being able to sit at home and obtain credit is excellent.

ROBERT E. SNODGRASS, M.D.
Indianapolis

To the Editor:

I think your new (CME) series from the I.U. School of Medicine with the quizzes is excellent. Let's have more!

THOMAS BROWN, M.D.
Medical Director
Centro Medico San Jose
Ecuador

From the Indiana Court of Appeals

Chiropractors Fail to Stop Licensing Board's Action

Two state chiropractic associations lacked the requisite standing to sue over a state Medical Licensing Board rule defining the scope of chiropractic practice, an Indiana appellate court has ruled.

The Medical Licensing Board of Indiana adopted a resolution in 1972 that said chiropractic practice did not include the performance or interpretation of cardiogram procedures, blood tests, microscopic urinalysis, Pap smears and other diagnostic tests. In 1976, the Board proposed that the resolution be promulgated as a rule and that other rules be enacted defining those acts constituting the unlawful practice of medi-

cine by chiropractors. Before the Board took any further action, two state chiropractic associations filed suit to enjoin the Board's action. A trial court granted the injunction, and the board appealed.

Reversing the decision, the appellate court said that the Associations had not suffered any injury. The associations claimed that their members would be subject to malpractice claims for failing to comply with the Board's rule. However, that did not establish an injury to the Associations giving them standing to sue. The lower court's order was vacated.

—*Medical Licensing Board of Indiana vs. Indiana State Chiropractic Association, Inc.*, 373 N.E. 2d 1114 (Ind. Ct. of App., March 29, 1978.)

Reprinted courtesy of THE CITATION, AMA, July 15, 1978

Navy Medicine. The time is right.

Now's the time to look into Navy Medicine. It was never more attractive than it is today. As a physician in the Navy, you'll practice the finest in patient care and followup, in facilities that rank with the top anywhere. With the support of a skilled paramedical and administrative staff. As a General Medical Officer or a Navy Flight Surgeon, or in your own specialty—or in one of ours like aerospace medicine or undersea medicine.

You'll start right in with a full-scale practice and, depending on individual circumstances, earn \$30,000 or more a year to start. You can count on time to relax, with 30 days' paid vacation earned each year. Whether you choose a medical facility in the United States or overseas or sail with the Fleet, you'll combine professionalism, public service and adventure in a way of life that's uniquely Navy.

The time is right. To learn more, to find out whether we have openings in your specialty, and to find out if you qualify, contact:

LT. BOB JONES, R.N., B.S.N.
575 N. Pennsylvania St. R. 643
Indianapolis, IN 46204
(317) 269-6197 (COLLECT)

It makes sense now.

Tenuate® ©
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976
MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.
Licensor of Merrell®

References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

**Whether overweight is a
complicating factor...
or just uncomplicated overweight.**

Tenuate Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** 75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

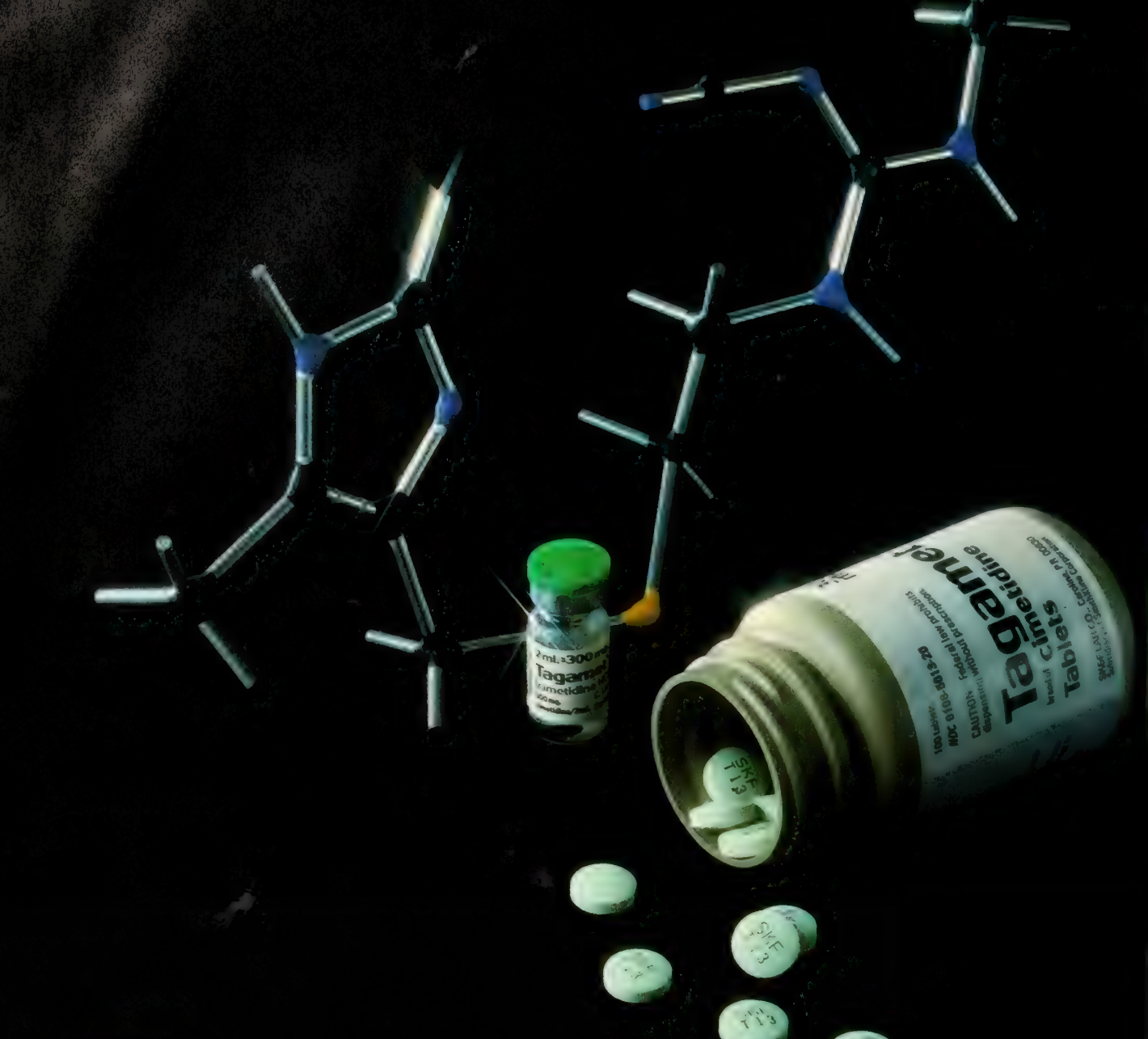
The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "... anorexic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

Merrell



For prescribing information see opposite page.



Tagamet[®]

brand of

cimetidine

How Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).

Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
a SmithKline company

NEW increased limits under ISMA sponsored income protection plan

33⅓% more in fact! You can now provide yourself monthly income disability protection up to \$2,000 from the previous limit of \$1,500 (subject to a participation of \$3,500 per month with other companies) if you are disabled and unable to work due to an accident or illness.

OTHER INSURANCE PLANS AVAILABLE

In addition to this disability income protection that now helps you replace more of your earned income when you cannot work, there are four other Association sponsored supplemental insurance plans. You, as an ISMA member physician or professional corporation are eligible to add to your protection through these supplemental plans.

- **EXCESS MAJOR MEDICAL PLAN** provides coverage after your present plan is exhausted. Up to \$250,000 coverage and two deductibles available (\$15,000 or \$25,000). Unlimited surgical schedule and includes extended care and nursing home benefit.
- **OVERHEAD EXPENSE PLAN** provides needed dollars to help you pay off overhead expenses (employees' salaries, rent, utilities, property taxes, etc.) in the event of your disability. When disability strikes—your business overhead expenses keep right on going—even when you can't.
- **FAMILY LIFE INSURANCE PLAN** provides benefits up to \$60,000 in the event of your death.

ALL PLANS ARE ALSO AVAILABLE FOR PROFESSIONAL CORPORATIONS

COUPON

For information on the ISMA sponsored

☐ Income Protection Plan

☐ Overhead Expense Plan

☐ Professional Corporation

☐ Excess Major Medical Plan

☐ Family Life Insurance Plan

Administered by

Dr. _____

Street _____

City _____ Zip _____



Mail to:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

j. russell townsend and associates

Indiana Paramedic Ambulance Personnel Gain State Certification

SIREN WAILING, blue lights flashing, the "Flying Squad" streaked through the streets of Belfast, Northern Ireland, in 1965. A military group heading off a rebel attack? No, it was the first paramedic ambulance service attempting to reduce the high pre-hospital morbidity and mortality rate associated with myocardial infarction.

Five years later the Los Angeles County Fire Department became the first U.S. entrant into paramedicine, later epitomized in the hearts of today's children and adults as "Emergency One" on television. Three years later, in May 1973, paramedicine came to Indiana as the then Marion County General (Wishard Memorial) Hospital Ambulance Division hit the street with its first class of paramedics.

In response to a growing public awareness of the need for improved emergency services and of the necessity to maintain federal highway funds as a result of the federal 1966 Highway Safety Act and 1969 Emergency Medical Services Act, Governor Otis R. Bowen, M.D., set aside July 23, 1973, for the Governor's Conference on Emergency Medical Services.¹ More than 700 persons with a special interest in the subject of emergency medical services participated.

The ultimate outcome of the conference was realized in 1974 with the passage of Senate Enrolled Act No. 151, Public Law 55, establishing the Indiana Emergency Medical Services Commission.² This law provides for the state certification of Indiana providers of emergency services, their ambulances and equipment, and their personnel, referred to as Emergency Medical Technicians (EMTs).² The deadline for this required certification was set for Jan. 1, 1978.²

The author is a staff physician and instructor with the Emergency Services Department, Center for Trauma and Critical Care, Methodist Hospital Graduate Medical Center, Indianapolis 46202.

Engrossed House Bill No. 2057, Public Law 142, amended Public Law 55 in March 1975 to include Advanced Life Support, defined as:

"... care given at the scene of an accident or illness, during transport, or at a hospital by a paramedic which is more advanced than that usually rendered by an emergency medical technician, and which may include, but is not limited to, the following:

- (1) defibrillation;*
- (2) endotracheal intubation;*
- (3) parenteral injections of appropriate medications;*
- (4) electrocardiogram interpretation; and*
- (5) emergency management of trauma and illness."*³

Provisional State certification was extended Oct. 1, 1975 to paramedics who were affiliated with a (provisionally) certified paramedic organization, were certified as an EMT in Indiana, and who completed an approved course in advanced life support care.³ Since Jan. 1, 1978 full paramedic certification by the State has been required, which in addition to the above provisional certification requirements, requires applicants to satisfactorily demonstrate knowledge and skill in emergency care.⁴

To establish a means for the paramedic to demonstrate his skill and knowledge as required by the Rules and Regulations of the Emergency Medical Services Commission, the Emergency Paramedic Test Construction and Evaluation Committee was created in March 1977, and held its first meeting March 29, 1977.

Members include: Carolyn Cunningham, M.D., Indianapolis; James Finfrock, M.D., Elkhart; Gareth Gilkey, M.D., Indianapolis; John C. Johnson, M.D., Indianapolis/Greencastle; Glen McClure, M.D., Sullivan; Phillip Myers, M.D., South Bend; and David Ross, M.D., Gary. The members represent regionally those areas of the State with active provisionally certified paramedic programs at the time of the committee's formation.

Emergency Medical Technicians

JOHN C. JOHNSON, M.D.
Indianapolis

The committee determined that each provider organization should be responsible for the documentation of a satisfactory level of physical skill attainment by each paramedic certification candidate. Thus, the committee's goal was to construct a written instrument to test the candidate's knowledge and to set a minimum level of attainment necessary to qualify to seek certification by the State of Indiana.

In October 1977, practicing provisionally certified paramedics throughout the State were introduced to 128 pages of questions compiled by the committee from the U.S. Department of Transportation (DOT)/National Highway Traffic Safety Administration (NHTSA). The questions were based on a text entitled, "National Training Course: Emergency Medical Technician—Paramedic," authored by Nancy L. Caroline, M.D., Department of Critical Care Medicine, University of Pittsburgh.

The statistical evaluation of the field test of these questions, along with the input of Dr. Phillip St. John, chairman, Department of Zoology, Butler University, made possible the production of the final test instrument. The committee's report and the examination were accepted by the Emergency Medical Services Commission in October 1977.

The examination is divided into four sections to be given over a seven-hour period on a single day at a central location. There are two general knowledge sections (150 questions each), one electrocardiogram reading and interpretation section, and a problem-solving section. A cumulative total of 70% is required to pass the examination. The examination may be taken in its entirety three consecutive times without having to retake a paramedic instructional class to seek certification. Recertification will be required every three years following the initial certification.

From the streets of Northern Ireland to the streets of Indiana, paramedicine has evolved over the last 13 years. With the continued and increasing support of Indiana hospitals and physicians, and with the continued involvement of the members and staff of the Indiana Emergency Medical Services Commission, Indiana paramedicine will improve and in turn there will be a reduction in the prehospital morbidity and mortality of Indiana citizens.^{5,6}

ADDENDUM

On June 17-18, 1978 the first Indiana State Certifying Examination for Emergency Paramedics was administered to 68 candidates.

Thirty of the 68 (44%) passed the examination on the first attempt.

The remainder have two additional chances to pass before being required to retake a paramedic training course approved by the State of Indiana.

It is anticipated that 32% of those failing the first exam will have passing marks on their first retake exam based on an analysis of their errors.

BIBLIOGRAPHY

1. "Recommendations and Resolutions: Governor's Conference on Emergency Medical Services," prepared by the Indiana Regional Medical Program, July 23, 1973.
2. Senate Enrolled Act No. 151, Public Law 55, State of Indiana. (IC 1971 16-1-39).
3. Engrossed House Bill No. 2057, Public Law 142, State of Indiana. (IC 1971 16-1-40).
4. "State of Indiana, Official Rules and Regulations for the Operation and Administration of Advanced Life Support," Emergency Medical Services Commission, adopted for promulgation Nov. 12, 1976.
5. Liberthson, R: "Prehospital ventricular defibrillation," *N.E.J.M.* 291:317-321, Aug. 15, 1974.
6. Feinleib, M, and Davidson M: "Coronary Heart Disease Mortality," *JAMA* 222:1129-34, Nov. 27, 1972.

Strongly Opposed by ISMA

DHEW Renews Second Consultation Efforts

The DHEW is renewing its efforts to inform Medicare beneficiaries that they have the right to seek a second consultation before undergoing elective surgery. In Indiana, the Medicare Part B Carrier, Mutual Medical Insurance, is contacting physicians for their participation in the program and making referrals when second opinions are requested.

The program isn't new; it's just that DHEW is now actively publicizing guidelines it has recently developed. DHEW will pay 80% of "reasonable costs" for beneficiaries enrolled in Medicare Part B who seek a second (or third) consultation about elective surgery. (Most states—including Indiana—will pay all reasonable fees for a second opinion sought by a Medicaid beneficiary.)

DHEW regional administrators implemented the new guidelines on Sept. 1. The thrust of the guidelines is to provide consumers the names of qualified physicians for a second consultation—a move strongly opposed by ISMA physicians and the Indiana Academy of Family Physicians, which

feels such lists imply disapproval of certain physicians.

Physicians will not be required to provide second opinions as a condition for participation in the Medicare or Medicaid programs. However, DHEW expects them to participate voluntarily when asked. Patients seeking second consultations may ask their physician for a referral, select a physician on their own, or seek advice on referrals from local sources.

DHEW has three ways for patients to learn where they can get such local referrals:

- Through local Social Security District Offices
- Through local Welfare offices, or
- By calling DHEW toll free at 1-800-325-6400.

Referral centers will encourage patients to ask the first physician to transfer pertinent medical records and information to the consulting physician. Patients will also be informed which physicians accept Medicare/Medicaid payments for their consulting services.

Answer these questions before you buy your next car.

☐ ☐ 1 Do you enjoy driving a new car?

YES NO

☐ ☐ 2 Would you like to hold your monthly car payments to a minimum?

YES NO

☐ ☐ 3 Would you prefer to make no down payment whatsoever on your next new car?

YES NO

☐ ☐ 4 Would you like to know the advantages of all the new car models comparing them side to side?

YES NO

☐ ☐ 5 Would you want possible savings on insurance costs?

YES NO

☐ ☐ 6 Would you spend 30 minutes to find out about the most exciting new way to drive a car?

YES NO

If you answered YES to any of these questions, you should talk with Dave Waite Leasing about your next car.

One of our transportation consultants will go over all the facts with you. He can advise you on the make and model car that best suits your personal needs.

If you're in the new car market, you owe it to yourself to spend thirty minutes at one of our many convenient locations.

See for yourself what so many people have learned: Dave Waite Leasing is The Intelligent Alternative to buying a car.

Dave Waite Leasing

TRANSPORTATION CONSULTANTS, INC.

The Dave Waite Leasing Program has been officially endorsed for the membership of the Indiana Dental Association, The Indiana Grain & Feed Association, Inc., the Home Builders Association of Indiana and the Indiana State Bar Association.

Indianapolis (3 locations) • Anderson/Muncie • Lafayette • Kokomo • Bloomington

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® ^{Buccal}5 ^{Oral}10 ^{Oral}25
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

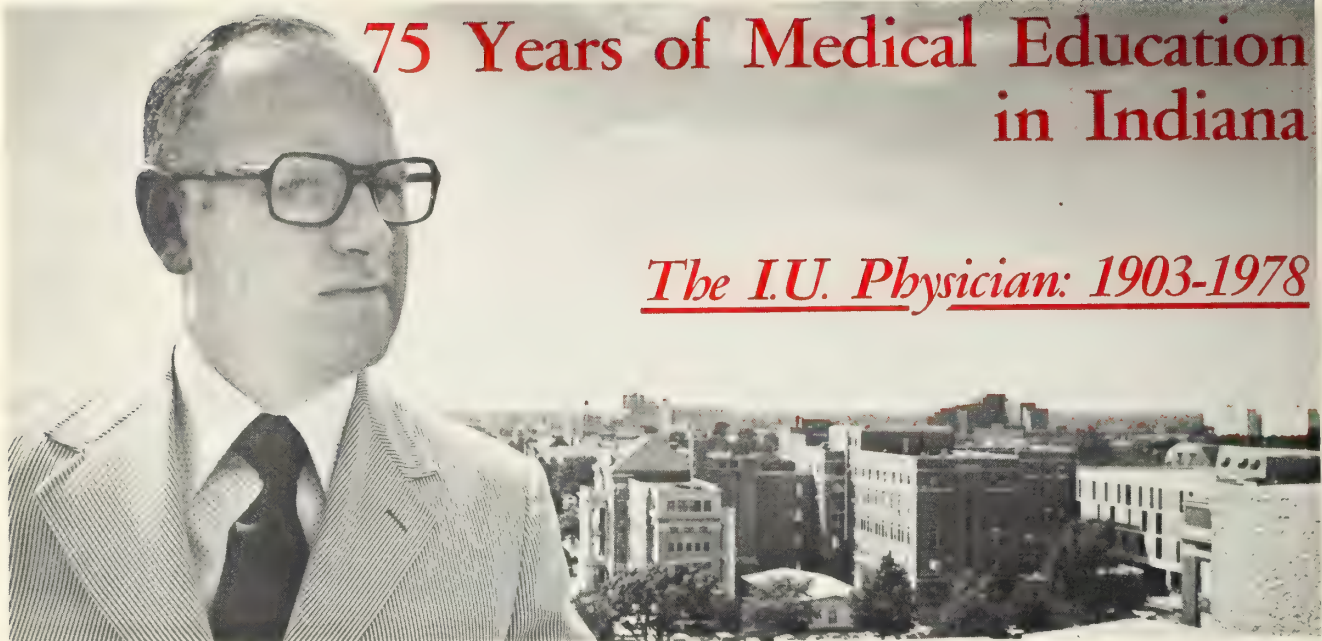
Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057





**Above, Steven C. Beering, M.D.,
Dean, I.U. School of Medicine. PHOTO BY LACEY**

The year 1978 marks the 75th anniversary of Indiana University School of Medicine. To commemorate this event, a booklet, "The I.U. Physician," has been prepared by the School, giving the history of its development. Members of the Indiana State Medical Association and members of the School of Medicine's Alumni Association will soon receive a copy of this publication.

The Progressive Era of American History is that period of time from the turn of the century to the beginning of World War I. From the medical perspective, this is the period of the Flexnor Report, the termination of the proprietary school, and the rise of the state-supported medical school.

During the first 75 years of the state's existence, medical education was conducted throughout Indiana, both on the apprenticeship system and by means of the proprietary medical school. Indiana had no fewer than 15 medical schools in various parts of the state during this period (at Vincennes, New Albany, Evansville, LaPorte, Indianapolis, Fort Wayne and Marion).

The rapid growth of the scientific aspect of medicine during the 19th

century, and particularly during the last quarter of the 19th century, extended the formal aspects of medical education from a six months' didactic experience prior to the Civil War, to the four-year medical

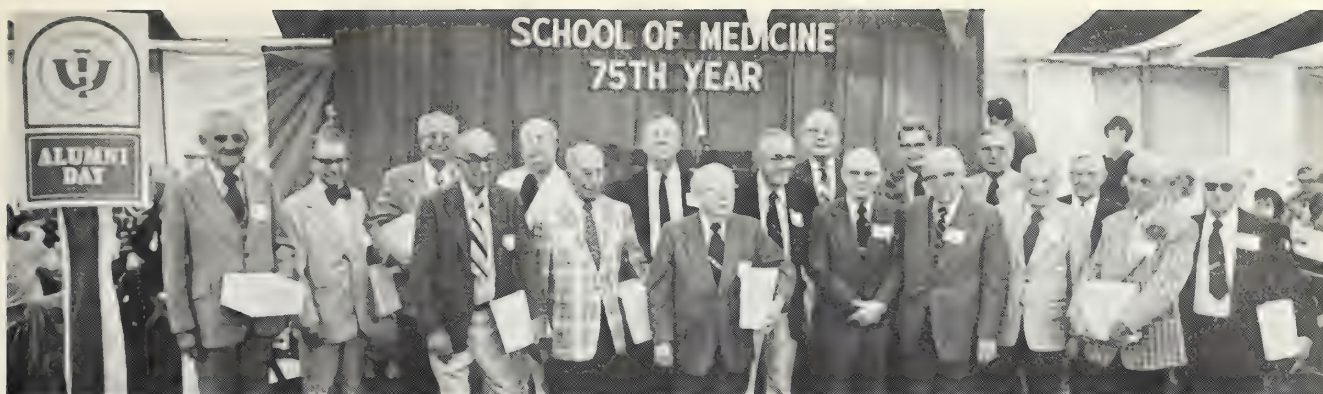
curriculum, with adequate premedical education being requested by the end of the century.

What constituted an adequate premedical education, however, posed a dilemma. A wide discrepancy existed between what was desired and what could actually be obtained. Nineteenth century educators realized that premedical college experience was desirable for the medical student. From the prac-

**CHARLES A. BONSETT, M.D.
PRISCILLA BROWN, M.A.
JOE G. LEHMAN, M.A.
Indianapolis**



The present I.U. School of Medicine, Indianapolis.



**Above, Alumni Day,
Class of 1928,
I.U. School of Medicine.**

PHOTO BY LACEY

tical point of view, however, the expenses of the medical school made the admission of a large number of students necessary (relatively few of whom had more than a high school education) to pay the bills. There seemed to be no solution to this problem. It was ultimately solved by the Johns Hopkins School of Medicine.

Johns Hopkins led the way in demonstrating to the nation the most effective way of producing the most capable physician. By the turn of the century the nation had a plethora of physicians, but most were inadequately trained. Johns Hopkins, the Baltimore millionaire merchant philanthropist, opened his university in 1876, his hospital in 1889, and the medical school in 1893. Although Hopkins died in 1873, his concept of the modern university was brought to reality under the skillful administration of David Coit Gilman.

The Johns Hopkins Medical School provided the ultimate in medical education in terms of facilities, instructors, and students. The University determined the requirements and the curriculum, and exercised complete control of the student's education. Unlike the proprietary schools, Johns Hopkins School of Medicine was not vitally dependent upon the student for support, and hence could be more critical of the student's qualifications and performance. By the turn of the century, the superior capabil-



The second building used to house the I.U. School of Medicine, above, is referred to in Medical Museum Notes, page 943. School No. 1 appears on this month's cover. BASS PHOTO



Emerson Hall, shown here in a 1930s photo, was the third building used to house the School of Medicine. Occupied in 1918, it was originally rectangular. The south wing in the foreground was added in 1928.



Robert W. Long Hospital, built in 1914, is no longer used as a hospital.

ity of the Johns Hopkins School was generally recognized by medical educators. The Flexnor Report of 1910 made this conspicuous to the public at large.

Indiana was ahead of most states in its progressive medical reforms. The first attempt to emulate Johns Hopkins was made by Dr. George Edenharter, superintendent of Central Indiana Hospital for the Insane, who erected the "Pathological Department" on the grounds of Central Hospital in 1895, in order to bring the resources of the state to bear on the problems of medical education and research.

During the 1890s, under the guidance of President William Starr Jordan, Indiana University also brought the resources of the state to bear more effectively on these problems. President Jordan initiated the first courses in biological sciences. By the turn of the century these courses were equivalent to the first year of medical school. Dr. William Lowe Bryan, who succeeded Dr. Jordan, expanded this program by bringing in Dr. Burton Myers from Johns Hopkins to chair the department of anatomy. With this addition, Indiana University extended its courses to cover the first two years of medical education. With the assistance of Dr. John Barnhill and others, a four-year program was established by 1906. In 1908 the Medical College of



Dr. Charles Emerson, fourth from left, makes his rounds in Long Hospital. He was Dean of the I.U. School of Medicine during the Twenties.

Indiana and the Central College of Physicians and Surgeons at Indianapolis, together with the Fort Wayne College of Medicine, united with Indiana University in providing their faculty and facilities. Since that time the medical school and its resources have grown tremendously. Dr. Charles Emerson and Dr. Willis Gatch, both Johns Hopkins graduates, successively became Deans of the I.U. School of Medicine and directed the school during its initial decades.

It is interesting to note that, as

during the 19th century, medical education in Indiana is again on a state-wide basis, with centers for medical education now located at Gary, South Bend, Fort Wayne, Lafayette, Muncie, Terre Haute, and Evansville, in addition to the campuses at Indianapolis and Bloomington. How this has come about, as well as how the School of Medicine has developed over the past 75 years, is the subject of "The I.U. Physician." This booklet is due to be published this month. You should have your copy soon.

100 mg

250 mg

500 mg



Tolinase[®]

tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

© 1977 THE UPJOHN COMPANY

**When painful spasm
is the presenting
symptom...**



in functional G.I. disorders*

Bentyl[®]

(dicyclomine hydrochloride USP)

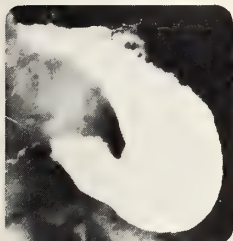
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects[†]

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS.** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS.** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy, hepatic or renal disease, ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia, increased ocular tension; loss of taste; headache, nervousness, drowsiness, weakness, dizziness; insomnia; nausea, vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION.** Dosage must be adjusted to individual patient's needs.

Usual Dosage Bentyl 10 mg capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water.) Bentyl 20 mg: Adults: 1 tablet three or four times daily. Bentyl Injection: Adults: 2 ml (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE.** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

Merrell

MERRELL NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215 U.S.A.



Forget Everything

you ever knew
about borrowing

Money

Introducing a new loan: **THE PROFESSIONAL**

so unique that we have over
\$4,000,000.00 in personal loans
made to Physicians and Dentists.

Unique Features...

- **PAY ANY AMOUNT ANY
DAY OF THE MONTH.**

In good times, pay more. During slow
periods, pay the minimum.

- **WE MAKE HOUSE CALLS.**

A collect call is all that's necessary
to begin processing your loan. We
will come to your home, office or hos-
pital to close your loan at your
convenience.

This confidential loan is made for
any good purpose . . . long term
or short . . . \$10,000 to \$50,000.
An interest-bearing loan, it can be
repaid in varying amounts and on
any day. You pay only for the time
you use the money. Call today.

PROFESSIONAL LOAN DIVISION

Ask for Colin G. Haza
Assistant Vice President

110 East Washington Street
Indianapolis, Indiana 46204
Phone (317) 631-1311

Indianapolis

**Morris
Plan**



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article continues my discussion of the gift and estate tax sections of the Tax Reform Act of 1976 (TRA) and the proposed changes which are in the Technical Corrections Bill (TCA).

There are three significant aspects about the TRA's changes of the estate tax rates. However, prior to my discussion about these changes, the reader should review the new method for computing **taxable** estate which is, in general, the amount on which the estate tax is imposed. The computation of taxable estate is as follows:

Total estate

Less exclusions for transfers involving:

- Gifts made more than 3 years prior to the decedent's death;
- Qualified retirement plans;
- Certain jointly owned property;
- Limited powers of appointment.

Total exclusions:

Gross estate

Less deductions for:

- Claims;
- Funeral expenses;
- Administration expenses;
- Casualty losses.

Total deductions:

Adjusted gross estate

Less deductions for:

- Charitable contributions;
- Marital transfers;
- Devises to minors.

Total deductions:

Taxable estate

As to the application of the estate tax rates, it should first be noted that the former rate schedules (one for gift taxes and one for estate taxes) have been repealed by the TRA for taxable gifts or death transfers which are made after 1976. These two former rate schedules (on which the gift tax rates used to be only three quarters of the estate tax rates, in any corresponding brackets) have been replaced by a "unified rate schedule," which appears in section 2001 (c). The new schedule is "unified," because there is just **one** schedule of rates, for both gift and estate taxation.

The second significant aspect about the new estate tax rate schedule is that

it is quite high in comparison with the former estate tax rate schedule. At the lower end, the former estate tax schedule had a rate of 3% on taxable gifts up to \$5,000. However, the new estate tax schedule, at the lower end, has a rate of 18% on taxable estates up to \$10,000. And, at the upper end, the former estate tax schedule has a rate as high as 77% on taxable estates over \$10,000,000. However, the new estate tax schedule, at the upper end, has a rate which is fixed at 70% on taxable estates over \$5,000,000. I think that the easiest way for persons to put these new estate tax rates in perspective is to identify the rates with the present income tax rates. That is, at the low point, the new estate tax rates (at 18%) are just four points higher than the lowest income tax rates. And, at the highest point, both the estate tax rates and the income tax rates are fixed at 70%. Specifically, the new estate tax rates appear in the accompanying table.

The third significant aspect about the new unified gift and estate tax rate schedule is the manner in which section 2001 applies the rates in order to compute the estate tax. That is, the new estate tax computation is made in two steps.

The first step (section 2001 (b) (1)) in the application of the new estate tax rates is to apply the rates to the sum of the decedent's: taxable estate; and, adjusted taxable gifts. For this purpose, a decedent's **adjusted taxable gifts** means the total of the taxable gifts which the decedent made (during the decedent's life and after 1976) other than gifts which are includible in the decedent's gross estate, for estate tax purposes. For this purpose, the term **taxable gifts** includes **taxable gifts** which were made by the decedent's spouse and which the decedent consented to split, for gift tax

CONTINUED ON NEXT PAGE

Taxable Amount Over—	Taxable Amount Not Over—	Tax on Amount in Column A	Rate of Tax on Excess Over Amount in Column A
	\$ 10,000		18%
\$ 10,000	20,000	\$ 1,800	20%
20,000	40,000	3,800	22%
40,000	60,000	8,200	24%
60,000	80,000	13,000	26%
80,000	100,000	18,200	28%
100,000	150,000	23,800	30%
150,000	250,000	38,800	32%
250,000	500,000	70,800	34%
500,000	750,000	155,800	37%
750,000	1,000,000	248,300	39%
1,000,000	1,250,000	345,800	41%
1,250,000	1,500,000	448,300	43%
1,500,000	2,000,000	555,800	45%
2,000,000	2,500,000	780,800	49%
2,500,000	3,000,000	1,025,800	53%
3,000,000	3,500,000	1,290,800	57%
3,500,000	4,000,000	1,575,800	61%
4,000,000	4,500,000	1,880,800	65%
4,500,000	5,000,000	2,205,800	69%
5,000,000	—	2,550,800	70%

TAX TIPS

purposes, under section 2513. The clear-cut case of gifts which are includible in the decedent's gross estate is where gifts are made by a donor within three years of the donor's death, and therefore, are includible in the decedent's gross estate for estate tax purposes, under section 2035. Because such three-year gifts are required to be included in the decedent's gross estate, such gifts are not again added into the decedent's taxable gifts which are added to the decedent's taxable gifts which are added to the decedent's taxable estate, in step one of the computation.

The second step (section 2001(b) (2)) in the application of the new estate tax rates is to apply the unified rates to the total taxable gifts which a decedent made during the decedent's life and after 1976. For this purpose, the term **taxable gifts** includes taxable gifts which were made by the decedent's spouse and which the decedent consented to split, for gift tax purposes, under section 2513.

Then, the second estate tax (the lower tax, which is really a gift tax) is subtracted from the first estate tax (the larger tax, which is really a combined gift and estate tax), and the difference between the two taxes is the decedent's estate tax prior to any of the estate tax credits.

Aside from the new gift and estate tax marital deduction computations, there is no aspect of the routine gift and estate tax computations which has caused more misunderstandings than the relationship of **adjusted taxable gifts** to the new estate tax computation. First, it is difficult for "oldtimers" to realize that the new estate tax computation has been changed in order to be similar, but not identical, to both the pre-1977 and the post-1976 gift tax computations.

That is, in a nutshell, both the prior and new gift tax computations are made by a two-step computation which involves: computing a gift tax on all taxable gifts which the donor has made during the donor's life (including the taxable gifts which were made **prior** to the taxable period which is involved and the taxable gifts **of** the taxable period which is involved); and then, by subtracting from this first gift tax, the gift tax on the taxable gifts which were made **prior** to the taxable period which is involved. Obviously, the first gift tax (on

all taxable gifts **through** the taxable period which is involved) is greater than the second gift tax, namely, the gift tax on taxable gifts **up to** the taxable period which is involved. And, the difference between these two gift taxes is the gift tax **of** the taxable period which is involved. Thus, if the reader understands the prior (and new) gift tax computations, then the reader should be able to fairly quickly understand the new estate tax computation.

As the reader probably knows, the prior estate tax computation used to be made in a one-step computation which was similar to the prior (and present) income tax computation. That is, the prior estate tax computation was made by merely adding the flat amount of estate tax and the percentage amount of estate tax—based upon the decedent's taxable estate. And, the prior (and present) income tax computation was, in general, determined by merely adding the flat amount of the income tax and the percentage amount of income tax—based upon the individual's taxable income.

Now, however, the estate tax (like the prior and the new gift tax) is determined by a two-step computation (section 2001 (b)) which "backs into" the estate tax by computing one tax (section 2001 (b) (1)), and then by computing another tax (section 2001 (b) (2)), and by subtracting the second tax from the first tax. To say this still another way, the new unified estate tax computation is similar, but not the same as, to the prior (and new) gift tax computation—if the reader will think of the decedent's taxable estate as though such taxable estate were the decedent's "final" gifts.

That is, step one of the new (and prior) gift tax computation computes a gift tax on all taxable gifts which a donor has made during the donor's life—including the taxable gifts of the taxable period which is involved (section 2502 (a) (1)). And, step one of the new estate tax computation computes an estate tax on all taxable gifts which the decedent made during the decedent's life (after 1976)—plus the decedent's final "taxable gifts," that is, the decedent's taxable estate (section 2001 (b) (1)). Thus, in general, in both cases, step one in the computations is to take into account all of a donor's (or decedent's) taxable gifts (including, in the case of the gift tax, the taxable gifts of the taxable period which

is involved) and (including, in the case of the estate tax, the taxable estate at the decedent's death). From this view, the principal difference between step one of the new gift tax computation and step one of the new estate tax computation is that the new gift tax computation takes into account all taxable gifts which the donor has made during the donor's **life**, but the new estate tax computation takes into account only the taxable gifts which the decedent made **after** 1976.

As to step two of the new gift tax computation, this second step requires the computation of a gift tax on all of the taxable gifts which a donor has made during the donor's life—**up to** the taxable period which is involved (section 2502 (a) (2)). And, the step two of the new estate tax requires the computation of, in a sense, a gift tax on all of the taxable gifts which a decedent has made during the decedent's life (after 1976)—**up to** the decedent's final transfers, that is, up to the decedent's death "gifts," that is, up to the decedent's death transfers (section 2001 (b) (2)).

Then, in the case of both the new gift tax computation and the new estate tax computation, the tax which is computed under step two (the smaller tax) is subtracted from the tax which is computed under step one (the larger tax), and the resulting difference is: in the case of the gift tax, the gift tax (before credits) of the taxable period which is involved; and, in the case of the estate tax, the estate tax (before credits).

Perhaps the computation of the new estate tax can be better understood by viewing the computation as follows. In step one of the estate tax computation, the rates are applied to a donor-decedent's post-1976 taxable gifts plus the donor-decedent's taxable estate. And, in step two of the estate tax computation, the rates are applied to the donor-decedent's post-1976 taxable gifts. Thus, a tax on taxable gifts plus taxable estate minus a tax on taxable gifts equals the tax on the taxable estate. Therefore, unlike the gift tax computation (which is the computation of a gift tax in step one and the computation of a gift tax in step two, with the resulting difference being a gift tax), the estate tax is a computation of a gift-estate tax in step one and the computation of a gift tax in step two, with the resulting difference being an estate tax.

ISMA ANNUAL MEETING

October 22-25 • Clarksville

ROCKWOOD

INSURANCE COMPANY OF INDIANA

Professional Liability Insurance Specialists

Physicians, Surgeons, Dentists

Hospital Professional Liability

Represented by

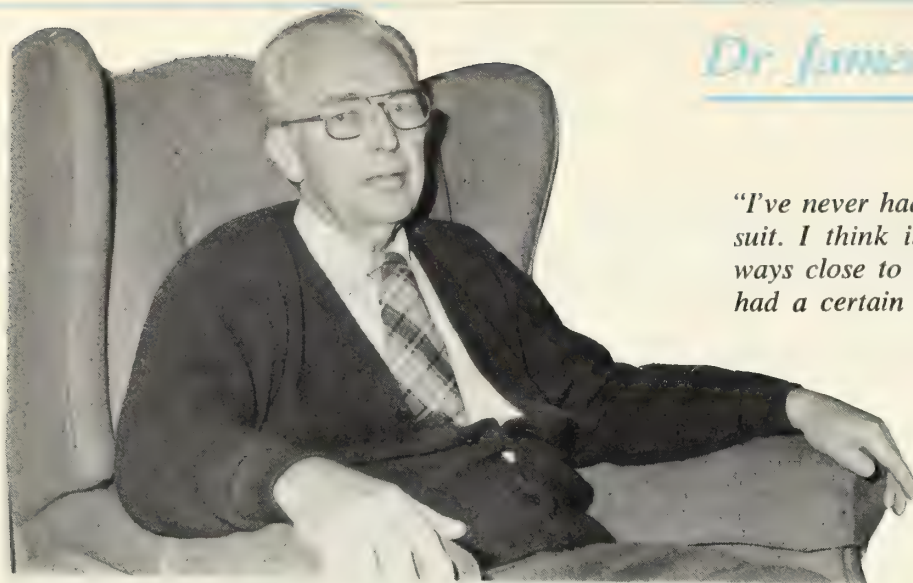
Health Care Provider Insurance Agency, Incorporated

INDIANAPOLIS . . . Hadley-Mahoney Co., 3640 N. Washington Blvd. 46205
(317) 924-5331

MICHIGAN CITY . . Lindenmeyer Insurance Associates, Inc.
801 East Eleventh Street 46360
P.O. Drawer C
(219) 879-7301

SEYMOUR Wenco, Inc., Room 20, Vehslage Building
P.O. Box 518 47274
(812) 522-2931

SOUTH BEND . . . Hepler-Smith Insurance, Inc.
511 West Colfax Avenue
P.O. Box 1875 46634
(219) 232-4889 (Toll Free 1-800-552-2910)



Dr. James M. Pfeifer

"I've never had the threat of a lawsuit. I think it's because I was always close to my patients and they had a certain trust in me. . . ."

HIS HAIR IS WHITE and he is a few years older but he still has a certain sparkle and gleam in his eyes when he talks about medicine.

It's easy to imagine that certain sparkle has been with Dr. James M. Pfeifer since he began practicing medicine in 1934.

Dr. Pfeifer retired last December. There were no flowery celebrations, just a note through the mail notifying his patients.

But to his patients, Dr. Pfeifer was more than just a physician one visited when sick; he was a friend.

"I always enjoyed being close to my patients," he said. "I think you accomplish more. You gain respect and their confidence.

"It's really a two-way street," Dr. Pfeifer continued. "Both the patient and the doctor gain more knowledge if they really know each other.

"I was always honest with them," he remembered. "If I couldn't communicate with them and thought they could get better medical attention, I told them so."

Over 43 years have come and gone since Dr. Pfeifer began practicing medicine in Lawrenceburg, but he remembers his start like it was yesterday.

"I began practicing during the summer of '34 in the office of Dr. F. M. Mueller," he said. "The office was located at Front and Second Streets, where we stayed for seven years.

"During the '37 flood we moved to Greendale," said Pfeifer. "We worked as an emergency unit at Schenley Distillers. Completely surrounded

by water, we conducted everything from medical practice to surgery there."

Originally from Arcola, Ill., where his father was in the seed business, Dr. Pfeifer received his medical degree from Indiana University School of Medicine.

He practiced his internship at St. Francis Hospital and General Hospital, Indianapolis, before beginning a family practice in Lawrenceburg.

"I'd been interested in being a doctor for as long as I can remember," he said. "I was good friends with a doctor's son in Illinois and that doctor made a big impression on my life.

"My parents always gave me encouragement," Dr. Pfeifer said. "They knew I had the determination to make it."

Dr. Pfeifer met his wife, the former Alice Mueller, on a blind date arranged by her sister.

After his marriage to Miss Mueller in 1934, Dr. Pfeifer moved to Lawrenceburg to take over her father's practice.

In 1940, the Pfeifers built the home where they now reside, in Greendale.

In 1942, Dr. Pfeifer left his practice to join the military service. He served as a flag surgeon with the medical corps in the Pacific.

When Dr. Pfeifer returned to Lawrenceburg in 1946, he bought the building at 319 Front Street and converted it into an office. His office continued at the same location until he retired.

Before Dr. Pfeifer left Lawrenceburg to serve the country, he was interested in getting a hospital established in the Dearborn County area.

"We couldn't get the community involved," he remembers. Dr. Leslie Baker, Dr. Fred Houston and I were all interested but the community wasn't."

Reprinted with permission from
REGISTER PUBLICATIONS, Lawrenceburg, Ind.
Story and photo by Jeanne Jahnigen.

That Certain Sparkle

It was about five years after World War II when Dr. Pfeifer, along with the others, got the wheels turning. Before Dearborn County Hospital opened its doors in 1959, Dr. Pfeifer had served on the staffs at St. George, Christ, Good Samaritan, and Margaret Mary Hospitals.

"We all worked very hard to get the hospital going," he said. "When the hospital finally did open we had to work together. We were small and had only a few doctors. We learned to get along together and I think that's one reason why the hospital has operated so well across the years."

Serving as Dearborn County Hospital's first chief of staff, Dr. Pfeifer, along with other doctors who've grown with the hospital, has worked hard to maintain its standards.

Many things have changed through the years and one thing Dr. Pfeifer, a former president of the Dearborn-Ohio County Medical Society, is especially proud of is the hospital's development.

"The hospital has developed so much since its inception," he said. "I've watched it grow and seen the development of new additions. I've seen the development of an intensive care and cardiac department. The hospital is more rounded now. I think its growth has attributed to its high and good standards and to the men who do the good work."

Not only has Dr. Pfeifer seen changes in the hospital but also in medicine.

"Medicine has changed tremendously," he said. "There were no penicillin or sulphur drugs when I began practicing. We used to treat patients with simple drugs and serum."

"The serum we used was not refined," Dr. Pfeifer continued, "but by the end of World War II penicillin had been invented. Now there has been penicillin advancement. Probably the greatest advancement is the great refinement of drugs."

Malpractice is another phase of medicine that has changed as the medical profession has grown older.

"When I first began practicing I paid less than \$50 a year for malpractice insurance," Pfeifer said. "Last year I paid \$1,500 for the same type of insurance. I've been lucky. I've never had the threat of a lawsuit. I think it's because I was always close to my patients and they had a certain trust in me."

"I think the threat of lawsuits today has caused a lot of excess pressure," Dr. Pfeifer said. "You have to protect yourself and your patient."

The Pfeifers have three children, Nancy Carrier, Greendale; Dr. James F. Pfeifer, a cardiologist in Oakland, Calif., and Dr. David Pfeifer, a dentist, who is a commander in the U.S. Navy. They also have five grandchildren.

"I came from an old fashioned family where the wife never worked," said Pfeifer, "and I maintained that idea in our house."

"Alice was always the public relations person in our family," he said. "She was and always has been involved in many community activities and functions."

Mrs. Pfeifer, a former Latin, art and English teacher at Guilford School, was elected one of the Cincinnati Enquirer's Women of the Year in 1975.

She's involved in the Cincinnati Fine Arts Fund, Phi Beta Psi Sorority, Dearborn County Chapter of the American Cancer Society, and Dearborn County Hospital Auxiliary.

Mrs. Pfeifer admitted when her husband works 80 hours a week, a doctor's wife can become very lonely.

"You have to turn to other things," she said. "You can't be self-indulgent; you've got to have contact with other people."

"You've also got to realize that his life as a physician comes first," Mrs. Pfeifer continued.

"I feel sorry for the young physicians today," he said. "Some of them are just in medicine for the money part of it."

"They lose the greatest part of medicine when they look at their practice that way," Dr. Pfeifer continued, "and that is working with the people and the confidence and trust they gain in each other."

"I've always loved my work," he said. "I loved the contact with the people. That's the most important part. You can't practice the fear of medicine. I always laid the goods on the table and gave my patients a choice of treatments."

"I'll miss practicing medicine," he said, "and I miss all of the good office help I've always had."

Dr. Pfeifer's retirement days will be filled with traveling, photography, relaxing and electronics. He has designed a stereo system and built a color television for his home.

"Honesty is one of the most important parts of medicine," he said. "I'm proud of the friendships I developed with my patients, and I think it's one of the best compliments you can get when a patient considers you more than a physician, but a true friend."

CANCER CORNER

EVERY PHYSICIAN'S OFFICE—
A CANCER DETECTION CENTER

Cancer Research—\$36.5 Million

The Society invested more than \$36.5 million in research during fiscal year 1977, funds that were aimed mostly at finding new methods of prevention, early detection, treatment and rehabilitation.

Highlights: Discoveries take years to become widely accepted methods of cancer control. Yet techniques still in the experimental stage can give us an exciting glimpse into promising fields and possible future patterns of cancer control. Here are a few examples:

- Molecular biologists and virologists are searching for a common denominator approach to cancer prevention through the study of "oncogenes." These are cancer-causing genes found in all animals, including humans, but which are normally suppressed by some body mechanism.

- A simple, inexpensive blood test based on unique chemical substances in cancer cells and in different parts of the body may be able to indicate whether an individual has cancer, and where that cancer is.

- Synthetic vitamin substances known as retinoids are demonstrating the ability to reverse the malignant growth process in several cancers.

- A new technique makes previously lethal doses of the powerful cancer drug, methotrexate, safe for the treatment of several cancers.

- Certain drugs and hyperthermia (the superheating of body tissues) are being used to increase the effectiveness of radiotherapy.

- Bone-marrow transplants are enhancing the effectiveness of chemotherapy for some patients.

Environmental Research: The Society is especially concerned with preventing cancers linked to environmental influences, including those affected by life styles and personal health habits. This is the one area of research in which the Society does much of its own work, instead of awarding grants to independent investigators.

Of the 385,000 cancer deaths in 1977, it has been estimated that 80% are related to environmental causes. Many of these are lung cancer deaths due to cigarette smoking. Other hazards include over-exposure to the sun, excessive drinking, obesity and exposure to certain industrial chemicals. Some researchers claim that dietary factors are also involved.

Continuing studies are being made into the hazards of asbestos—already found to increase the risk of lung cancer, gastrointestinal cancer and other conditions among asbestos workers. One study nearly completed is examining the effect of asbestos dust on non-workers who live near asbestos factories.

Some roofing chemicals have been implicated in higher rates of cancers affecting the lungs and some other organs. Conversely, cotton textile dust was found not to have any cancer-causing properties. A study now

being completed is testing suspicions that anesthesiologists have a high risk of cancer. Other pending studies involve tunnel workers, tile setters and textile dyers.

Priority Funding: In 1977 the Society launched its Research Development Program to provide needed funds quickly for special top priority projects.

In cancer research, important gains often are made by seizing the right opportunity; by capitalizing on imaginative ideas and venturing into little-known areas. Research is also a changing process, and after a grant is awarded, new developments within a project often call for additional funds. Other totally new research opportunities arise after the Society's research budget is set.

The new ACS program provides a total of \$5 million during an initial test period of more than a year. Grants are awarded to promising investigators within three months of application.

These top-priority funds have gone to researchers such as the California investigator analyzing hormone action and cell growth; the Illinois scientist involved in special chemotherapy research; the New York recipient testing a new way to detect prostate cancer (which claims 20,000 lives a year); and the pilot program in northern California which is speeding research advances from the laboratory to the doctor's office.

Peer Review: All ACS grant applications must undergo a rigorous peer review screening process. They are judged on the basis of merit, qualifications and productivity of the investigator, relevance, need and the probability of the project's eventual contribution to cancer control.

Mammography Risks

In recommending this valuable detection and diagnostic x-ray technique, the Society balances known benefits against presumed risks. There is an ongoing need for early diagnosis and prompt treatment of breast cancer to save lives. There is also a need to avoid undue exposure to radiation.

The 27 Breast Cancer Detection Demonstration Projects supported jointly by the Society and the National Cancer Institute continued to find breast cancer in an extremely early and highly curable stage. The program, which began in 1973, is nearing completion in its examination of 280,000 asymptomatic women, ranging in age from 35 to 74.

There is convincing evidence that low-dose mammography can detect breast cancers which are too small to be felt. To date these projects have found more than 2,500 unsuspected breast cancers—45% of them by mammography alone. Had mammography not been used, these cancers would have gone undetected. At

CONTINUED ON PAGE 1014



This asthmatic isn't worried about his next breath...

**he's active
he's effectively
maintained on**

QUIBRON[®]

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 8-4294R

COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan — compatible with coexisting diseases
- Vasodilan — compatible with concomitant therapy
- Vasodilan — compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows

Possibly Effective

1. For the relief of symptoms associated with cerebral vascular insufficiency.
 2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease
- Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7 4268

THE JOURNAL, in cooperation with the Division of Postgraduate and Continuing Medical Education of the Indiana University School of Medicine, offers its readers a Continuing Medical Education program. This is the 9th in a series of CME articles, produced by the faculty of the School of Medicine and is supported by a grant from its Division of Postgraduate and Continuing Medical Education.

As an organization accredited for continuing medical education, the Indiana University School of Medicine certifies that this continuing medical education activity meets the criteria for 1 credit hour in Category I for the Physician Recognition Award of the American Medical Association provided it is used and completed as designed.

To obtain Category I credit, complete the quiz on Page 999.



Depression in the Elderly

SUSANNE BLIX, M.D.
HUGH C. HENDRIE, M.B. Ch.B.
Indianapolis

ABSTRACT

Apart from dementia, depression is the most important of the psychiatric disorders that affect the elderly. In some community surveys, almost half of an apparently normal elderly population had depression scores on a self-rating scale that could be considered in the depressive range in younger patients. More severe disturbances in mood, primarily of depression and anxiety, were found in about 14% of individuals over 65 in a survey conducted in England.

Depressive disorders are associated with suicide. The suicide rate for elderly males increases with every decade. The suicide rate for females also increases with age, but tends to peak at an earlier age level. Depression is important because of the severe consequences of the syndrome for the elderly which includes, as well as suicide, rapid physical and mental deterioration, and also because it is readily treatable. Therefore, correct diagnosis is important. Treatment is almost always a combination of biological and psycho-social approaches.

From the Department of Psychiatry,
Indiana University School of Medicine.

THERE HAS BEEN AN INCREASE in interest recently in the mental health problems of the elderly. This is due in part to the somewhat belated recognition of the current population trends in the United States.¹ In 1970, in this country there were 20 million people aged 65 years or older, comprising 10% of the population. This number is estimated to reach 30 million people by 2000 A.D. Approximately 95% of the elderly live in the community, while 5% are institutionalized. In 1970, 25% of men and 10% of women aged 65 and over were still fully employed. Twenty-five percent of all elderly Americans had incomes that were estimated to be lower than the poverty threshold. The elderly, 10% of the population, comprise 20% of the poor in the United States. Owing to a differential death rate between the sexes, there is a much higher percentage of elderly men who are still married

than elderly women. Widows outnumber widowers 3 to 1.

EPIDEMIOLOGY

Estimates of the total prevalence rate for moderate to severe mental disorders in people over 65 range from 25% to 40%.² The increasing recognition of mental illness in old age, together with population changes, has led to a marked increase in the number of elderly being treated in general hospitals for psychiatric problems. In Denmark, in 1957, 27% of patients in the psychiatric wards in general hospitals were aged 60 years or over. In 1962, this proportion was 50%.² A similar trend is seen in general hospital psychiatric wards in the United States.

While all types of mental disorders are found in the elderly, the most common syndromes are those of depression and dementia. In some community surveys, almost half of an apparently normal elderly population had depression scores on a self-rating scale that would be considered in the depressive range in younger patients. More severe mood disturbances, primarily depression and anxiety, were found in 14% of people over 65 years of age in a community survey in England.³

While there is general agreement that the prevalence of depression increases with age, there is less agreement as to the meaning of this relationship. It would appear that depression is not causally related to aging per se, but is rather related to the concomitants of aging in our society. Two factors are particularly prominent. These are socio-economic status and physical disease and/or disability. In most studies, depression is directly related to low socio-economic class.¹ It is particularly prevalent in those individuals who have experienced a decline in socio-economic status with ad-

vancing age. The association is less clear with those individuals who have functioned at a low socio-economic level throughout their lives.

Physical ill health and disability stands out as the clearest and most consistent correlate of functional mental disorders among the aged.³ This is particularly true with elderly men. The effects of physical illness on patients are complex, and would include both the direct influence through pain, metabolic disturbances and immobility, as well as more indirect effects of feelings of helplessness and dependency. Most depressive episodes in the elderly are precipitated by loss, e.g., death of family or friends. However, the effect of loss on the aged person is somewhat paradoxical. In some ways, the elderly are more stoical in their response to loss. Nevertheless, it would appear that the accumulation of such losses in this age group is sufficient to overwhelm even the sturdiest defenses.

SUICIDE

Suicide rates increase with aging, particularly in males. The suicide rate for females also increases with age, but tends to peak at an earlier age level than with males. In 1966, 28% of all suicides were committed by people 60 years of age or over.⁴ In populations under the age of 40 years, there are more than seven unsuccessful suicide attempts for every completed suicide. Over the age of 60, this ratio reverses itself with the number of completed suicides exceeding the number of attempts.⁵ There is also a trend for the elderly to use more violent means of suicide, for example, jumping from heights, drowning, hanging, and shooting. "Clearly, the suicidal threats and attempts in older people are almost always genuine, and involve a very high degree of risk," indicating "a much more unambiguous wish to die."⁵ In one comprehensive study of 30 suicides occurring in patients over the age of 65, 87% had an affective disorder of some type. The intensity of the symptoms, however, was not necessarily severe, and did not always impress doctors or relatives. Many suicides had occurred with an illness lasting less than one year in duration, and in 83%, there had been a physician consultation within three months of the successful suicide. A significant proportion had been living alone for less than one year, usually because of the death or admission to a hospital of a friend or relative.

As is the case with depression, suicide rates in the elderly are associated with such factors as lowering socio-economic status, loss of spouse and physical illness.

SYMPTOMATOLOGY

Table 1 lists the common symptoms of depression in the elderly. In this population, the depressive

TABLE 1

Depression in the Elderly: Common Symptoms and Signs

Lowering of mood
Feeling alone
Feeling helpless
Feeling hopeless
Feeling powerless
Feeling the future is gloomy
Feelings of guilt
Difficulty sleeping
Decreased appetite
Irritability
Anxiety
Withdrawal
Slowed psychomotor responses
Agitation
Paranoid ideation
Obsessive symptoms
Compulsive symptoms
Histrionic symptoms
Hypochondriacal symptoms

syndrome often comprises an admixture of the symptoms of anxiety as well as depression. The syndrome also often combines the clinical features suggestive of "endogenous" and "reactive" depression. The patient may describe a lowering of mood, decreased appetite, and difficulty sleeping as well as symptoms suggestive of pervasive anxiety. Feelings of loneliness, hopelessness, helplessness, powerlessness, and guilt are often expressed. The patient may also complain of an inability to cope with daily activities, and have the impression of slowing of thought processes and memory impairment. In severe depressions, the patient may express delusions of guilt, sin, illness or impending death. The physician may observe an increase in restlessness, irritability or marked agitation. More commonly, the patient becomes increasingly withdrawn with slowed psychomotor responses. Although memory, orientation and intellect are generally unaffected, the marked slowing of response may make assessment of these areas difficult, and lead to the erroneous conclusion of dementia (*vide infra*).

When the aforementioned symptomatology is present, the diagnosis of depression is usually not difficult. However, not infrequently in the elderly, the syndrome can be present without the prominent feature of a depressed mood. The elderly patient may become preoccupied with apparently unjustifiable physical complaints, and have an unwarranted conviction of physical disease.

Hypochondriasis occurring in this age group, particularly in a previously uncomplaining patient, is often an indication of an underlying depression. Similarly, in patients living alone, depression should be suspected when there is evidence of unexplained malnutrition or self-

neglect. Sometimes the depression manifests itself by a sudden, premature decision to retire which the patient attributes to feelings of overwork. Similarly, unreasonable and sometimes repetitive changes of routine or residence in the elderly heralds the onset of depression. Some patients, particularly those with a previous history of neurosis, may present with the predominant features of anxiety, phobia, and an upsurge of histrionic behavior that may mask the underlying depression.

In all of the above cases, a careful history and mental status by the physician will clarify the correct diagnosis of depression.

DIAGNOSTIC PROBLEMS

The Secondary Depressions. As with all psychiatric syndromes, depression in the elderly can be subdivided according to presumptive etiology into primary and secondary groups.⁶ As some of the causes of secondary depression are potentially reversible and as the primary and secondary depressions cannot be differentiated solely on phenomenological grounds, it is important for the physician to investigate carefully all elderly patients with this syndrome. A careful drug history is essential as the depressive syndrome can be precipitated by certain drugs, particularly the Rauwolfia Alkaloids, Aldomet, or L-Dopa. Some infectious disease states, such as urinary tract infections or influenza, can also precipitate depression. While all chronic illnesses occurring in the elderly, as mentioned previously, can be associated with depression, this is particularly true for the cancers, depression often being the first symptom of cancer.

A considerable number of patients with early cerebral degeneration may exhibit a transient depressive syndrome. The physician may

first observe a state of despair and pessimism in the patient with no objective foundation. In more severe cases, florid nihilistic delusions may occur. It is only later that the progressive intellectual and personality impairment becomes manifest. These patients represent a significant suicidal risk, and although the correct diagnosis is senile dementia, they should be treated for their depression.

"Pseudodementia." One of the most crucial diagnostic distinctions which has to be made in the elderly is between depression and dementia in those patients who present with complaints of memory impairment.⁷ This is particularly so because depression is a potentially treatable condition. If the correct diagnosis of depression is not made and the proper management instituted, in addition to the increased likelihood of suicide, the patient may lapse into a state of immobility with clouding of consciousness, constipation, fecal impaction, and incontinence which may eventually prove to be fatal. In general, depression can be distinguished from dementia by its relatively rapid onset and a possible history of previous episodes in either the patient or the family. However, in some elderly patients, particularly in those who live alone, this information is not always attainable.

The diagnostic problem can arise in several ways. While there is no evidence that the elderly person invariably suffers from intellectual deterioration, it is true that they do tend to exhibit a slowing of psychomotor responses. This slowing of response is particularly exacerbated in depression, and can be misinterpreted by both patient and physician as evidence of cerebral degeneration. A careful review of cognitive function, taking into consideration the slowing of response, will demonstrate that intellectual

function is intact in these patients. The diagnosis is even more difficult in a sub-category of elderly patients with depression who indeed show evidence of a cognitive deficit. These patients are generally from the lower socio-economic class with a history of below-average educational attainment. In these patients, the cognitive deficit probably represents a lifelong problem, and is not related to progressive dementia. Treatment of depression in these patients alleviates their symptomatology. As mentioned previously, it is not uncommon for patients who are suffering from dementia to experience transient initial depressive symptomatology. Again, in these patients, the depression should be treated.

TREATMENT

The treatment of depression in the elderly is not dissimilar to that of depression occurring in any other age group. The treatment regime involves consideration of the organic therapies (chemotherapy and electroconvulsive therapy) and/or psycho-social therapies. In almost all depressions of moderate to severe intensity in the elderly, both organic and psycho-social approaches are usually necessary. In patients with depression, a decision has to be made by the physician whether or not to hospitalize. This depends upon a number of factors, including an estimate of the suicidal risk and consideration of the risks in the administration of the various therapies. As these risks are increased in the elderly, it is appropriate for the physician to be more willing to suggest hospitalization for patients in this age group.

Chemotherapy General Principles. There are a number of physiological changes that occur with aging which have considerable metabolic consequences upon the activity of the psychoactive drugs. In general, these

changes result in the drugs tending to remain in the body longer and to have more prolonged biological activity.⁸ For example, in the elderly, the cardiac output can be reduced, circulation time can be increased; and renal blood flow, glomerular filtration rate, and tubular secretion can be reduced. In older persons, the fat-to-parenchymal tissue ratio is increased. Thus, lipid soluble compounds, including many psychoactive drugs, tend to accumulate in fatty tissues.

Plasma protein is reduced with age, so the amount of protein bound drug is reduced proportionately. In addition, it is possible that the brain may become increasingly sensitive to the pharmacological actions of drugs with aging because of decreased cerebral blood flow, changes in neurons, and other biochemical changes.

In general, most homeostatic mechanisms are decreased with aging, rendering them more likely to

disruption. The net effect of these changes is to increase both the clinical and toxic effects of drugs. In elderly patients, there is also an increase in incidence of physical infirmities. Many of these will be treated by potent pharmacological agents.

Thus, in the depressed elderly patient, there is always the possibility of dangerous drug-drug interactions. In view of the above, there are certain general principles involved in the administration of medication to the elderly:

- A careful physical examination, with the appropriate laboratory investigations, including an EKG, is important before beginning drug treatment. In addition, a careful medical history, with inquiry into the use of other medications, is essential.

- The drugs should be started at considerably lower dosages than for younger patients, generally about 50% of the starting dose for the young adult.

- The dosage should then be increased slowly, with careful monitoring for side effects.

- Once-a-day dosages, a common way of administering psychoactive medication in younger patients, should be used only with caution in the elderly.

- Polypharmacy should be avoided as much as possible.

Antidepressants. The most useful group of drugs for the treatment of depression are the tricyclic antidepressants. There is, as yet, no clear-cut way of determining which of the tricyclics will be the most useful for an individual patient. There is, however, some indication that depressed patients who have concomitant symptoms of agitation may respond best to the more sedative tricyclics, such as amitriptyline or doxepin. Patients with retarded depressions may respond best to imi-

TABLE 2

Tricyclics in the Elderly Patient: Important Side Effects

Anti-cholinergic properties

Blurred vision
Tachycardia
Difficulty in micturation
Dryness of mouth
Constipation

Mild hypomanic excitement

ECG and myocardial changes

Increased or decreased blood pressure

Acute brain syndrome

Disorientation
Clouding of consciousness
Impaired memory
Increased agitation
Paranoia
Hallucinations of all senses

pramine or protriptyline, which have less sedating properties. Imipramine should be started at about 50 mg. per day in divided doses, and be increased gradually by 25 mg. to 50 mg. per week as an outpatient, or possibly more quickly as an inpatient. Maximum doses for the elderly usually range between 75 mg. to 150 mg. per day. If the symptoms are not improved at the end of three-four weeks, another tricyclic antidepressant should be tried.

The dosage for the other tricyclics is equivalent to that recommended for imipramine. Remember that elderly depressed patients are particularly liable to develop drug side effects, the most important of which are listed in Table 2. One of the most difficult therapeutic problems is in those patients who have concomitant heart disease. In these patients, often, electroconvulsive therapy is the safest method of treatment.

Other antidepressant agents are of less use in the elderly patient. The monoamine oxidase inhibitors are generally avoided because of their toxicity. Stimulant drugs, such as amphetamine or methyl phenidate, have no role in the treatment of depression.

Other Psychoactive Agents. In patients who are severely agitated and depressed, other antipsychotic medication may be used, particularly the phenothiazines. Again, the general principles governing the use of drugs in the elderly have to be considered. The older patient is particularly susceptible to the neurological side effects of the psychotropic drugs, as well as the induction of hypotension. Hypnotics are frequently used in the elderly. However, they should be used only for short periods of time and judiciously. The safest hypnotics for the elderly are probably the benzodiazepines or chloryl hydrate. Barbitu-

rates should be avoided because of their propensity for inducing delirial reactions.

Electroconvulsive Therapy. This mode of treatment is particularly important in the elderly because of the potential dangerousness of the side effects of antidepressant medication. In some patients, it is safer than tricyclics, particularly if it is used in a modified form with succinyl choline and given unilaterally in the right hemisphere to minimize memory deficits.

Psycho-Social Approaches. Elderly patients, depressed or otherwise, often respond gratifyingly to interpersonal help. This is perhaps not surprising when one considers the plight and the feelings of loneliness of some of these patients. In many respects, the approach to psychotherapy of depressed patients is similar regardless of the age of the patient. Thus, the patient should have the opportunity to work through the nature of the precipitating loss with the therapist, with the appropriate expressions of feelings and the final acceptance of the meaning of the loss by the patient. At the same time, a clarification, and hopefully a modification, of critical environmental factors should be undertaken. Counseling with family members, or with the appropriate members of the patient's support system, is usually indicated. In addition to the above, there are several points which should be particularly made in discussing psychotherapeutic intervention in elderly patients.

- It requires time. Remember the cognitive slowing that occurs in elderly patients. This is exacerbated with the psychomotor retardation that often is associated with depression. It takes a patient, therefore, considerably longer to present and explore his feelings. It requires patience on the part of the clinician.

Time, unfortunately, is the one commodity that the elderly are unlikely to receive from professional (or non-professional) groups.

- An ability to empathize with the patient and understand his predicament is one of the hallmarks of good therapy with the elderly, as with other groups. It is perhaps even more important with the elderly because of their frequent feeling of being misunderstood.

- The elderly person has been characterized as undergoing a crisis of identity just as happens in other life stages, e.g., adolescence, only probably more severe. In all identity crises, therapy should be directed toward understanding the problem and helping to reconstruct new and realistic goals for the patient.

REFERENCES

1. Schwab, JJ: Depression among the aged. *Southern Medical Journal* 69, No. 8:1039-41, 1976.
2. Juel-Nielsen, N: Epidemiology. In *Modern Perspectives in the Psychiatry of Old Age*, ed. Howells, JG, Brunner/Mazel, Inc., 1975, pp. 24-31.
3. Roth, M: The psychiatric disorders of later life. *Psychiatric Annals* 6, No. 9:417-445, 1976.
4. Fann, WE, Wheless, JC: Depression in elderly patients. *Southern Medical Journal* 68, No. 4:468-473, 1975.
5. Payne, EC: Depression and suicide. In *Modern Perspectives in the Psychiatry of Old Age*, ed. Howells, JG, Brunner/Mazel, Inc., 1975, pp. 290-312.
6. Hendrie, HC: Organic brain disorders: Classification, the "symptomatic" psychoses, misdiagnosis. In *The Psychiatric Clinics of North America* (Hendrie, HC, ed.), 1:1:3-19, WB Saunders Company, 1978.
7. Roth, M: The management of dementia. In *The Psychiatric Clinics of North America* (Hendrie, HC, ed.), 1:1:81-100, WB Saunders Company, 1978.
8. Gulevitch, GD: Psychopharmacological treatment of the aged. In *Psychopharmacology, From Theory to Practice*, Barchas, JD et al, eds. Oxford University Press, 1977, pp. 448-468.

ANCEF[®]
brand of sterile
CEFAZOLIN SODIUM
GETS TO THE SITE



**OF SERIOUS
RESPIRATORY INFECTIONS**

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: **Hypersensitivity:** Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocytopenia and positive direct and indirect Coombs tests have occurred.

Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported.

Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® **IV**
IM
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

RAYNAUD'S PHENOMENON: Treatment of a Severe Case with Biofeedback

ABSTRACT

Raynaud's Phenomenon is a combination of vasospastic disease and an accompanying pathologic process. Medical and surgical treatments have proven to be unsatisfactory in the long-term management of these patients.

A case is presented of a 66-year-old white female with Raynaud's symptoms of 35 years duration and Scleroderma. She was admitted to the hospital with multiple small ulcerations on her fingers. She received 10 temperature biofeedback treatments in eight days. She was followed for six months post discharge.

Objectively, she significantly increased her baseline and maximum finger temperature during her training and, although these temperatures diminished in the six months of follow-up, they stayed above the pre-treatment baseline. Her ulcerations began to heal and she used fewer analgesics. The patient reported that her fingernails were growing for the first time in 10 years and her finger mobility was still improved.

JACK R. ADAIR, M.D.
DALE E. THEOBALD, Ph.D.
Indianapolis

RAYNAUD'S DISEASE has been described as a functional disorder of the cardiovascular system that involves intermittent spasm of the small arteries or arterioles of the hand and/or feet and sometimes the face.¹ The disease typically involves no organic pathology. When the syndrome is seen as a consequence of other pathological processes it is commonly called Raynaud's *phenomenon*.²

According to Shapiro and Surwit,³ the vasospasms typically produce a "three-stage color change, first blanching, then turning a cyanotic blue, and finally becoming bright red as the spasm is relieved and reactive hyperemia sets in." The vasospasms elicited or exacerbated by cold temperature and sometimes emotional stress are also accom-

From the Adult Psychiatric Clinic, Indiana University Medical Center, 1100 W. Michigan St., Indianapolis 46202.

The authors express appreciation to John M. Hague, M.D., for reviewing their manuscript. Send requests for reprints to Dr. Adair at the above address.

panied by painful swelling and stiffness. This disorder of the peripheral vasculature is not well understood. The etiology remains largely unknown. Shapiro and Surwit further suggest that it is unclear whether the vasospasms occur at the arterial, arteriolar or capillary level.

Perhaps even more unfortunate for those afflicted with Raynaud's disease, conventional medical-pharmacological and surgical treatments have not been satisfactory.^{2,4} Response to vasodilators is unpredictable. Surgical interventions such as cervical or lumbar sympathectomies produce inconsistent, temporary results and have undesirable side effects. Recently a form of learned physiological control (commonly called biofeedback) has shown some promise in treating Raynaud's disease and Raynaud's phenomenon. The technique involves first measuring peripheral blood flow in the affected areas (typical measures are surface skin temperature or photoelectric plethysmographic activity), then providing feedback of the physiological signal to the patient, and finally teaching the patient to alter the signal by use of various cognitive strategies. The biofeedback treatment is based on the demonstrated fact that digital vasomotor control can be made a voluntary response.⁵ In addition to its application in the treatment of Raynaud's disease, this biofeedback method of altering peripheral blood flow has also been shown effective in the treatment of migraine headache.⁶⁻⁹

The literature to date regarding the biofeedback treatment of Raynaud's disease is not conclusive. The clinical outcome literature consists of case study reports mostly anecdotal in nature.¹⁰⁻¹⁴ Although rapid relapse was a problem in two cases,^{12,14} all of the above case studies report successful treatment. These studies are informative but

additional case reports and controlled studies are needed. In the case report listed here, symptomatology in the patients was only mild or moderate and only one of the reports provide any systematic description of physiological changes noted during treatment.¹⁰

Presented below is a case study of a patient treated at the Indiana University Medical Center with temperature biofeedback. The case is noteworthy because it represents an extension of our current knowledge of the treatment of Raynaud's disease with biofeedback. The case illustrated the use of the technique with a patient with very serious involvement (to the point of amputation) of long duration (35 years). In addition, specific data regarding baseline temperature changes and temperature changes during treatment and follow-up are reported.

CASE REPORT

The patient is a 66-year-old white female. Her initial pain and discomfort appeared in the early 1940s. The classic symptoms of Raynaud's phenomenon, blanching followed by cycles of cyanosis and hyperemia occurring in response to cold and emotional stress, had been present for 35 years. In the mid 1960s, she began to develop hide bound skin, typical of systematic sclerosis, with involvement of the upper extremities to the middle of the arms, typical facial changes, and eventually mottled telangiectasia on the face and V area of the neck.

The patient was admitted to the hospital due to the extreme pain and ulceration of her hands, and a large ulcer on the lateral aspect of the right calf which was not healing normally.

Diagnoses at time of admission were Scleroderma and Raynaud's phenomenon. Both hands were seriously affected with the feet less seriously involved. At the start of

the treatment, nine of the 10 fingers had significant ulcerations. In the early 1950s, two digits of the right hand were amputated at the most distal joint due to gangrene resulting from decreased blood perfusion. The patient reported that no significant fingernail growth had occurred in the past 10 years. In 1952, a left side sympathectomy was performed with little positive result. The attending physician stated that a right side sympathectomy was not due to problems in healing.

At the time of admission, the patient was at risk for amputation of fingers, but this was not seen as a desirable alternative due to the healing problem. Vasodilators were not adequate in their effects.

Treatment sessions were conducted in the patient's room, a double room on a general medical ward. Ten treatment sessions were administered in an eight-day period. Recordings were made from an Autogen 1000 b Feedback Thermometer. Thermistors were attached to the volar surface of the middle digit of each hand at the start of each session. After a 10-minute accommodation period, initial temperature readings were taken from each hand. Next, the patient was given feedback of the right hand temperatures for 15 minutes and instructed in imagery techniques to facilitate hand warming. After the second training session, the patient was given instructions to practice warming her hands between treatments.

The patient's response to treatment can be evaluated using three sources of information: (1) objective measures of temperature changes, (2) observation of the patient's physical symptoms, and (3) the patient's report of her own progress.

The figure presents the temperature changes observed during treat-

ment and follow-up.

The follow-up interviews described in the *figure* were conducted two, four, and six months after treatment. The upper section of the *figure* displays the initial temperature of the patient's hands after the 10-minute accommodation period at the start of each session. As treatment progressed, a clear upward shift in the initial temperatures can be seen. While this shift is not evidence that the patient's hands remained warm at all times, it did correlate with a dramatic change in the color of the patient's hands while not in a treatment session and with the patient's report that her hands were not as cold as they had been. The upward shift appears to be rather stable during the closely grouped treatment sessions with some decrease over the six-month follow-up period. It remains, however, above the initial baseline level. The lower section of the *figure* reports the maximum temperature

achieved during the 15 minutes of temperature feedback. It can be seen that the patient was successful in increasing hand temperature after very few treatment sessions. It is also interesting to note that temperature changes occurred in both hands even though feedback was given from only the right hand. It seems that the vascular response was bilateral in nature.

Observation of the patient's symptomatology also revealed significant changes. Hand color changed from a blanched appearance to a more normal pink color. The ulcers on the patient's fingers began to heal. Further, the patient showed a decrease in her requests for analgesic medication. Soon after the start of treatment the patient's leg ulcer began to heal more normally. Since no temperature readings were taken from the lower extremities, no clear connection between the treatment and this healing can be made; however, prior to

treatment the leg ulcer was not healing.

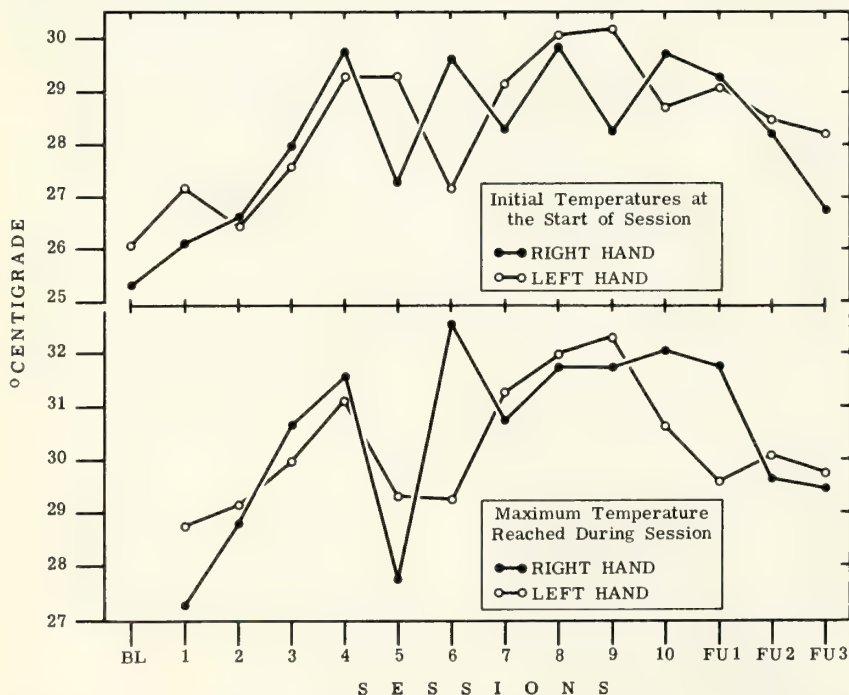
Perhaps the most impressive data came from the report of the patient herself. During the course of treatment she reported that stiffness and pain were significantly less. She also described the feelings of relaxation and rest during the training sessions as enjoyable. At the four-month follow-up (Feb. 1977) the patient reported an increase in movement in her fingers; she could easily make a fist; and no ulcers were present. Significant fingernail growth had also occurred. The patient reported great satisfaction about her progress even in the face of a very difficult winter. At the six-month follow-up, the patient reported continued progress. One small ulcer was present on the back of her right hand. By this time the fingernail growth was quite significant.

SUMMARY COMMENT

This case report provides an example of the apparently beneficial treatment of Raynaud's disease using biofeedback procedures. Symptoms of long duration were rather quickly mitigated. But this case study method cannot be seen as a method for demonstrating the effectiveness of biofeedback treatment—only controlled designs can provide that demonstration.

In addition, there are many other questions pertinent to the treatment of Raynaud's disease with this modality. For example, can patients with less severe symptoms be treated early and thus avoid the unfortunate progression of the symptoms? Does training individuals in voluntary control of peripheral vasodilation lead to less spasmodic activity in response to cold temperatures and/or emotional stress?

Research focusing on these and other similar questions is now underway at this and other centers.



Temperature recordings made during baseline, treatment and follow-up sessions.

It is our impression that a new and powerful method of treatment for Raynaud's disease may be emerging.

REFERENCES

1. Spittell JA: Peripheral vascular diseases. In Fairbairne JF, Juergens JL, Spittell JA (Eds.) Allen-Barker-Hines, *Peripheral vascular diseases* (4th ed.) Philadelphia, W.B. Saunders, 1972.
2. Fairbairne JF, Juergens JL, Spittell Jr, JA (Eds.): Allen-Barger-Hines, *Peripheral Vascular Diseases* (4th ed.) Philadelphia, W.B. Saunders, 1972.
3. Shapiro D, Surwit RS: Learned control of physiological function and disease. In H. Leitenburg (Ed.) *Handbook of Behavior Modification and Behavior Therapy*, Englewood Cliff, N.J., Prentice Hall, 1976.
4. Ruch TC, Patton HD, Woodbury JW, Towe AH, (Eds.): *Neurophysiology* (2nd ed.) Philadelphia, W.B. Saunders, 1965.
5. Surwit RS, Shapiro D, Feld JL: Digital temperature autoregulation and associated cardiovascular changes. *Psychophysiology* 13:242-248, 1976.
6. Sargent JD, Green EE, Walters ED: Preliminary report on the use of autogenic feedback training in the treatment of migraine and tension headaches. *Psychosomatic Medicine* 35: 129-135, 1973.
7. Wickramasekera I: Temperature feedback for the control of migraine. *Journal of Behavior Therapy and Experimental Psychiatry* 4:343-345, 1973.
8. Turin A, Johnson WG: Biofeedback therapy for migraine headaches. *Archives of General Psychiatry* 33:517-519, 1976.
9. Blanchard EB, Theobald DE, Brown DA, Silver BV, Williamson DA: A controlled comparison of temperature biofeedback and autogenic training with progressive relaxation training in the treatment of migraine headaches. *Proceedings of the Biofeedback Society of America*, 1977.
10. Blanchard EB, Haynes MR: Biofeedback treatment of a case of Raynaud's disease. *Journal of Behavior Therapy and Experimental Psychiatry* 6:230-235, 1975.
11. Jacobsen AM, Hackett TP, Surman OS, Silverber EL: Raynaud phenomena. Treatment with hypnotic and operant technique. *Journal of the American Medical Association* 225:739-740, 1973.
12. Peper E: Frontiers of clinical biofeedback. In *Seminars in Psychiatry*, Birk L, (Ed.) Vol. 5, New York: Grune & Stratton, 1973.
13. Schwartz GE. Clinical applications of biofeedback: Some theoretical issues. In D. Upper & D.S. Goodenough (Eds.) *Behavior Modification with the Individual Patient: Proceedings of Third Annual Brockton Symposium on Behavior Therapy*, Roche, Nutley, N.J., 1972.
14. Surwit RS, Biofeedback: A possible treatment for Raynaud's disease. *Seminars in Psychiatry* 5:483-490, 1973.

★
Specialized Service

IN
PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

Since 1899

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Southern Indiana Office: Kenneth W. Moeller, Representative
1810 Broad Ripple Avenue Telephone: (317) 255-6525
Mailing Address: P.O. Box 20132, Indianapolis 46220
Northern Indiana Office: Douglas O. Sellon, Representative
120 LaSalle West Bldg., Suite 304
South Bend, In. 46601 Telephone: (219) 289-7332

Legionnaire's Disease:

WEI-PING LOH, M.D.
Gary

A Case Report with Review of Literature

LEGIONNAIRE'S DISEASE has been known to the world since July 1976, when a major outbreak of atypical pneumonia occurred among members of the American Legion in Philadelphia. One hundred eighty-two cases, including 29 deaths, were encountered in the group. Six months later the responsible organism was identified as moderate pleomorphic gram negative bacillus measuring 0.3 to 0.4 μ m in width and 2 to 3 μ m in average length. The bacteria were identified in lung tissue and pleural fluid and could not be isolated from blood and sputum cultures.

Guinea-pig and embryonated egg inoculation, enriched Mueller-Hinton agar containing 1% hemoglobin and 1% Isovitalex in 5% carbon dioxide and Gimenez stain are generally needed for isolation and identification of the organism. The organism can be further characterized by biochemical studies, fluorescent antigen-antibody reaction and gas liquid chromatography. The reservoir of the organism is not completely known. Aerial transmission is possible. Several pertinent presentations on Legionnaire's Disease recently appeared in the New England Journal of Medicine.^{1,2,3,4}

The author is the chief pathologist at Methodist Hospital of Gary, Gary 46402. He is also a clinical professor of pathology at the Indiana University Northwest Medical Center.

The pathology in Legionnaire's Disease involves acute diffuse alveolar damage, hyaline membrane formation and alveolar debris in the lung tissue. Lobar type of pneumonia has been reported. In paraffin sections the organism stains poorly with tissue gram stain and giemsa stain, but does not stain at all with hematoxylin and eosin; however, it can be beautifully demonstrated by the dieterle silver impregnation procedure.

Clinically, the disease begins two to 10 days after exposure. In a typical case, the early symptoms include malaise, muscle aches, non-productive cough, and a slight headache. Within a day, there is rapidly rising fever associated with chills. The picture is almost identical with "flu" syndrome. Abdominal pain and gastrointestinal symptoms also occur. Temperatures commonly reach 102 to 105 F.

When first examined, the patient shows rales over the involved lung or essentially normal findings. Initial laboratory findings often include a leukocytosis (in 60%) with a left shift, proteinuria (in 20%), increased erythrocyte sedimentation (in 33%), and sometimes hyponatremia, mild azotemia, and elevation of serum SGOT alkaline phosphatase. Later on, chest x-ray shows patchy infiltration, minimal effusion and sometimes lobar consolidation. Cough may become productive.

The illness usually progresses

over several days after hospitalization. Approximately 15% to 25% of the patients die, either of shock or respiratory failure, or rarely renal failure.

For nonfatal cases the IFA (indirect fluorescent antibody) test is the test of choice for diagnosis. Samples of acute and convalescent sera along with a summary of the patient's clinical data should be submitted to the CDC through the state health department laboratories. The acute serum specimen should be obtained as early as possible. The convalescent specimens should include those collected during the second, fourth, sixth and eighth weeks of the illness. A significant rise in antibody titers (fourfold, 128 or greater) indicates a recent infection. For treatment, erythromycin and perhaps also tetracycline have had some effectiveness.

CASE REPORT

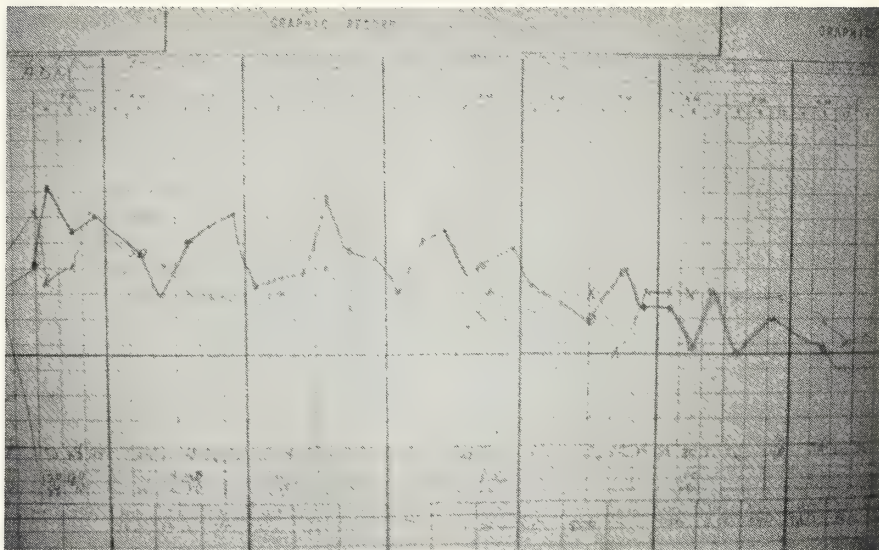
A 49-year-old obese male was admitted to the Broadway Methodist Hospital on Sept. 2, 1977 because of diabetic acidosis and fever of undetermined origin. He had been a diabetic for about eight years and had been taking DBI and Diabinese for his diabetes. For about three days prior to admission, he had been feeling very poorly and had malaise, anorexia, feverishness and headache. There were no cough, dysuria, nausea or vomiting. His urine was positive for acetone

in his physician's office.

He had an appendectomy many years ago. Review of systems revealed nothing significant.

On admission, his TPR were 104-130-30. Blood pressure was 142/90. His height was 5'6½" and weight 198 pounds. He was acutely ill. His red cell count was 4.3 million; hemoglobin, 12.3 grams; hematocrit reading 37.7; WBC, 12,100 with 75% segmented neutrophils, 17% lymphocytes and 8% monocytes. No parasites were seen in his blood smear. His RPR was non-reactive. His urine showed 3+ sugar, moderate acetone, 2+ protein and 3 to 4 WBC microscopically. His Hycel-17 profile showed sugar, 230 mg % and normal other components. His chest x-ray showed some slight stranding in the right upper lobe and right hilar calcifications which suggest a calcific primary complex from past granulomatous disease. Cold agglutinins of blood was not significant.

Physically he showed no skin eruptions or jaundice. There was no lymphadenopathy. His chest showed crepitant rales over the right lower lobe. The liver and spleen were not



Temperature chart of the patient showing fever for six days.

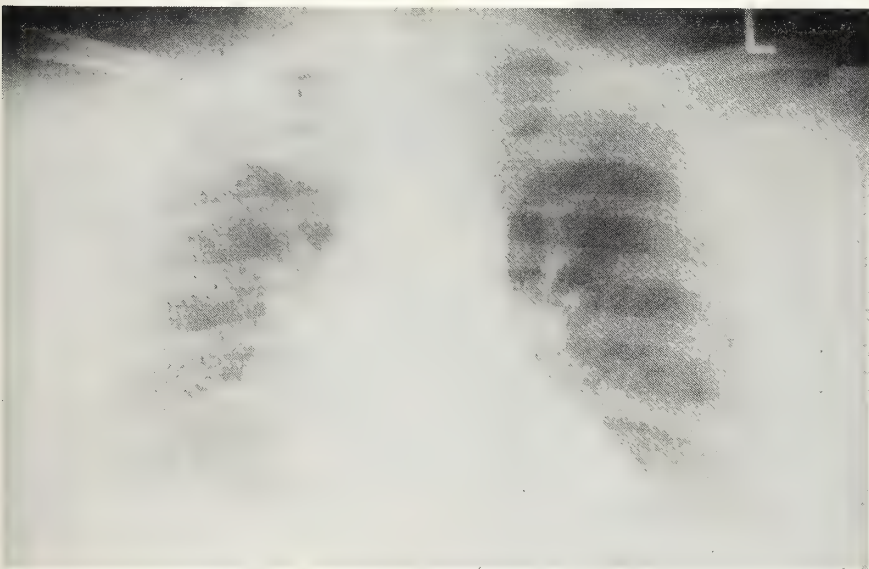
enlarged.

During his hospital stay, his diabetic acidosis was controlled by regular and Lente insulin. His temperature fluctuated between 101°F and 105°F during the first four days and then declined to remain normal after two more days. His WBC was 9,700 on Sept. 6. Another chest x-ray, on Sept. 8, showed some patchy infiltration in the right lower lobe posteriorly,

which may represent hypostatic pneumonitis. Less infiltration was seen in another chest x-ray taken on Sept. 11, when his fever disappeared. Sputum and urine cultures showed no definite pathogens. They were also negative for acid-fast organisms. Blood cultures showed no growth of aerobic or anaerobic organisms. Gastric washing also showed no pathogens. Antinuclear antibody test was negative. The initial treatment with 1.2 million units of Penicillin-G daily brought no response. He was then treated with gentamycin and Kefzol with satisfaction. He was discharged from the hospital in improved condition on Sept. 18, 1977. Results of the IFA tests of his acute and convalescent sera indicate a recent infection with the agent of Legionnaire's Disease.

DISCUSSION

In 1977 Indiana had two confirmed cases of Legionnaire's Disease.⁵ The case described above is one of the two cases. It was sporadic and nonfatal. Clinically it was close to a typical case described in the literature. No secondary cases were detected.



Chest x-ray of the patient showing borderline infiltration in the right lower portion.

Legionnaire's Disease appears to be new, rare and serious, but this is not entirely true. Before the 1976 outbreak in Philadelphia, there were at least three other outbreaks including the 1965 outbreak in the District of Columbia, 1968 outbreak in Pontiac, Michigan and the 1974 outbreak in Philadelphia. Those outbreaks were recently found to be serologically connected with the same infectious agent.

Since August, 1976 there have been 150 sporadic cases reported from 30 states including Ohio, Vermont, Tennessee and California.^{6,7,8} The sex incidence was approximately 3 to 1 in favor of male. Age of the patients ranged from 17 to 82 with a median of

53.5 years. The fatality rate was about 21.3%.

The risk is greatest in the elderly and in those who are undergoing immuno-suppressive procedures. The risk is also somewhat higher in smokers than in nonsmokers.

Legionnaire's Disease may not be rare at all. If we look for this disease in all cases of pneumonias and respiratory infections, we will be surprised by the large number of detected cases of Legionnaire's Disease.

REFERENCES

1. Fraser, DW, *et al*: Legionnaires' Disease: Description of an epidemic. *New England Journal of Medicine* 297:1189-1197, 1977.
2. McDade, JE, *et al*: Legionnaires' Dis-

ease: Isolation of a bacterium. *New England Journal of Medicine* 297: 1197-1203, 1977.

3. Chandler, FW, Hicklin, MD, Blackmon, JA: Legionnaires' Disease: Demonstration of the agent in tissue. *New England Journal of Medicine* 297:1218-1220, 1977.
4. Kass, EH: Legionnaires' Disease (Editorial). *New England Journal of Medicine* 297:1229-1230, 1977.
5. Telephone communication with Indiana State Board of Health, Dec. 1977.
6. Howe, CL: Legionnaires' Disease: The laboratory search for a baffling killer. *Medical Laboratory Observer*, pp 37-41, May 1977.
7. *Morbidity and Mortality Weekly Reports*, published by Center for Disease Control, 1977.
8. Keys, TF: A sporadic case of pneumonia due to Legionnaires' Disease, *Mayo Clin. Proc.* 52:657-660, 1977.

Road & Track just named
the 10 best cars for a
changed world.*
3 of those
names are...



GIGANTI
INC.

VOLKSWAGEN
PORSCHE
AUDI
6901 East 38th Street
Indianapolis, Indiana 46226
(317) 545-4211



*Road & Track June 1978

THE FOUNTAIN OF YOUTH

or

Where is the Estrogen Coming From

GEORGE S. PORTER, M.D.
JOHN M. WAMBO, M.D.
OLIN K. WILAND, M.D.
Richmond

IN 1930 MEYER¹ described an ovarian tumor that had both masculinizing and feminizing elements and called it a gynandroblastoma. Since then, there has been considerable confusion concerning the terminology of these tumors.

The tumor that was removed from the patient in the following case report was submitted to our pathologist, who described it as a gynandroblastoma. Slides were also submitted to the Committee for Consultation on Gynecologic Pathology of the Central Association of Obstetricians & Gynecologists, and there were three diagnoses of Sertoli-Leydig cell type tumor, two diagnoses of gynandroblastoma, and one diagnosis of granulosa-theca cell tumor (leutenized theca) —rule out metastatic bowel carcinoma because of unusual pattern of tumor.

These are interesting and rare tumors; however, the primary purpose of this article is to illustrate the importance of persisting in diagnostic efforts when a patient exhibits hyperestrogenism postmenopausally.

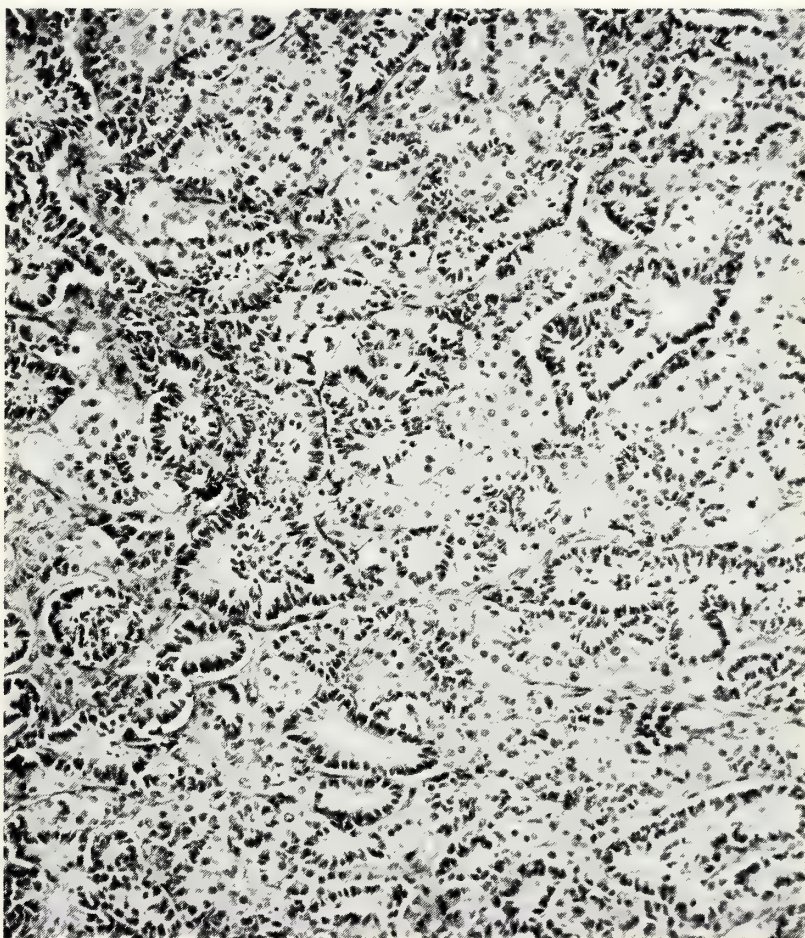
CASE REPORT

This patient was first seen in November 1974 at the age of 55, com-

plaining of intermittent postmenopausal bleeding since June of that year. She had been pregnant once in the past, which resulted in a spontaneous abortion. She had a cyst removed from her ovary and an appendectomy in 1945. She had an uneventful menopause in 1962. Her blood pressure was 140/90 and her general examination was com-

pletely normal. She had had a negative Pap smear from her family physician the previous month. A D&C was performed and this yielded only a few tiny fragments of endometrium, suggestive of cystic hyperplasia.

She was next seen in Jan. 1975 and stated that the only bleeding since her D&C had been two epi-



From the GYN Ltd., 900 Sim Hodgin Parkway, Richmond 47374.

sodes of spotting, one in December, and again the day before being seen in the office. Her examination was again normal and the Pap smear was negative.

She returned in April 1975, having had intermittent spotting for three months. Another Pap smear was obtained and the cornification indices showed 5% parabasals, 70% intermediates, and 25% superficials.

Because of this patient's persistent postmenopausal bleeding, evidence of cystic hyperplasia of the endometrium, and the cornification index, we were concerned about the possibility of a non-palpable estrogen producing ovarian tumor and elected to do an exploratory laparotomy. At surgery on April 28, 1975, both ovaries and the uterus appeared to be normal, although

the left ovary seemed to be slightly enlarged and firm. A total hysterectomy and bilateral salpingo-oophorectomy was performed.

The pathology report revealed a 15mm. intramural leiomyoma and cystic hyperplasia of the endometrium. Both ovaries were 25mm. in diameter. The right ovary was not remarkable. The left ovary contained a well circumscribed oval nodular mass which was 16mm. in diameter and yellow-white in color. This nodular mass in the left ovary microscopically was composed of multiple tubular structures, between which were cells showing features of luteinization. The tubular structures were consistent with an arrhenoblastoma, although granulosa cells may form tubules. The features appear to be those of gynandroblastoma. (Please refer to the figure for

a photomicrograph of this tumor.)

This patient's postoperative course was uneventful and she had a completely normal recovery from the surgical procedure.

DISCUSSION

This is a case report of an exceedingly rare and interesting non-palpable ovarian tumor, the only indication of its presence being the effects of the estrogen produced by the tumor. When confronted with a postmenopausal patient of this nature, it is obviously most important that you persist in diagnostic efforts until the cause of the hyperestrogenism is explained.

REFERENCE

1. Meyer R: Tubular (Testikular) and solide Formen des Andreioblastoma ovarii. *Beitr Path Anat* 84:485, 1930.

Business Opportunities: Tax Shelters For Professionals

If you're in a higher tax bracket, you'd probably like to reduce your present tax liabilities without reducing income. There is a way.

Tax free municipal bonds offer distinct advantages over other investments. In addition to high yields and tax free income, you also get low risk, diversity, capital appreciation, and marketability.

Many of the investments we offer are Indiana issues which are exempt from Indiana Intangibles Tax plus Indiana Gross Income Tax. At American Fletcher there is no annual management fee or commission charged on municipals. For a small fee (tax deductible) our Safekeeping staff will clip and collect your coupons for deposit to your checking or savings account.

American Fletcher can help. Our Portfolio and Money Market Group can acquaint you with the investment opportunities available in municipal bonds.

Call us today at (317) 639-8070 or address inquiries to: Portfolio and Money Market Group, American Fletcher National Bank, 101 Monument Circle, Indianapolis, Indiana 46277.

**"Give your income a shot
in the arm with tax free
Municipal Bonds from
American Fletcher."**

We want to be your bank.

**AMERICAN FLETCHER
NATIONAL BANK
AFNB**

CME QUIZ

Depression in the Elderly . . .

CONTINUED FROM PAGES 983-987

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.**

ANSWER THE FOLLOWING:

1. Estimates of the prevalence of moderate to severe mood disturbances in the elderly range from
 - a) 2%
 - b) 8%
 - c) 70%
 - d) .05%
 - e) 14%
2. All of the following are true except _____. The risk of suicide in the elderly is
 - a) Increased.
 - b) Higher in males than females.
 - c) Related to depression
 - d) Associated with the severity of the depressive symptomatology.
 - e) Higher in patients who have recently lost their spouse.
3. The most useful group of drugs in the treatment of depression in the elderly are the
 - a) Tricyclics.
 - b) Mono-amine oxidase inhibitors.
 - c) Amphetamines.
 - d) Phenothiazines.
 - e) Benzodiazepines.
4. The physiological changes that occur in the elderly result in
 - a) A lowering of the threshold for the toxic effects of the anti-depressants.
 - b) An increasing sensitivity to the clinical effects of the anti-depressants.
 - c) A prolongation of the biological activity of the anti-depressants.
 - d) All of the above.
 - e) None of the above.
5. In the psychotherapeutic approach to the elderly depressed patient it is important to remember that
 - a) Insight into the cause of the depression is unlikely to occur.
 - b) It requires more time and patience on the part of the physician because of psychomotor slowing of the patient.
 - c) Psychotherapy will be difficult because of the generalized intellectual deterioration which occurs with the elderly.
 - d) All of the above.
 - e) None of the above.

The following are answers to the CME quiz that appeared in the July 1978 issue of The Journal. The article upon which the questions were based was "The Causes and Medical Treatment of Urinary Calculi," by Richard Bloch, M.D. and Friedrich C. Luft, M.D.

1. c
2. b
3. c
4. a
5. c
6. e

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer sheet for Quiz: (Depression . . .)

1. a, b, c, d, e
2. a, b, c, d, e
3. a, b, c, d, e
4. a, b, c, d, e
5. a, b, c, d, e

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for credit for this month's quiz, send your completed, signed application before December 15, 1978, to the address appearing at the top of this page.

Practical Management of Diabetes for Family Practitioners

The following Type "K" questions are presented to the CME reader as a pre-test. The article upon which the questions are based, "Practical Management of Diabetes for Family Practitioners," by Charles M. Clark, Jr., M.D., will be published in The Journal next month. The questions listed below will also be reprinted, as a post-test. In this way, CME evaluators hope to determine the effectiveness of CME articles in improving the knowledge of physicians reading them. As usual, you are asked to indicate your responses on the answer sheet below.

Answer—
a) if 1, 2, 3 only are correct
b) if 1 and 3 only are correct
c) if 2 and 4 only are correct
d) if 4 only is correct
e) if all are correct

1. In attempting to determine if a patient has diabetes:
 - 1) the two hour postprandial glucose is the most sensitive.
 2. the fasting glucose is the most useful in determining the necessity for treatment.
 - 3) patients with mild abnormalities of either fasting or postprandial blood sugars frequently never develop clinical diabetes.
 - 4) the glucose tolerance test should be routinely performed if you suspect diabetes.
 - a)
 - b)
 - c)
 - d)
 - e)
2. If a patient has a fasting blood sugar of 150 mg% during an acute illness:
 - 1) he has a statistically increased risk for developing vascular disease.
 - 2) he will invariably develop clinical diabetes within the next 10 years.
 - 3) he is much more likely to develop diabetes if he is obese.
 - 4) a glucose tolerance test should be performed.
 - a)
 - b)
 - c)
 - d)
 - e)
3. When treating the obese, adult onset diabetic with diet:
 - 1) caloric restriction is more important than carbohydrate restriction.
 - 2) modest caloric restriction with weight loss of 3-4 pounds per month is frequently more effective than more severe caloric restriction.
 - 3) diets high in carbohydrate and low in fats and total calories may be effective in lowering both blood sugar and serum triglycerides.
 - 4) weight loss alone without changes in carbohydrate content will improve blood sugar control.
 - a)
 - b)
 - c)
 - d)
 - e)
4. Maintenance of blood sugars near normal in diabetic patients can be expected to reduce the incidence of or delay the onset of:
 - 1) diabetic symptoms.
 - 2) diabetic neuropathy.
 - 3) diabetic cataracts.
 - 4) heart attacks.
 - a)
 - b)
 - c)
 - d)
 - e)

CME PRE-TEST

5. In the adult, diabetes mellitus is associated with an increased risk of cardiovascular disease in:
- Americans and Western Europeans.
 - all countries and ethnic groups studied.
 - women much more so than in men.
 - poorly treated patients only.
- a)
b)
c)
d)
e)
- BEST POSSIBLE ANSWER. ONE ANSWER ONLY:**
6. Oral agents in the treatment of diabetes:
- are safer than insulin in the elderly patient with renal or hepatic disease.
 - lower the incidence of cardiovascular disease.
 - are usually effective in normalizing blood sugar even in the patient with poor dietary adherence.
 - usually can be avoided when there is good dietary adherence.
 - are useful in patients on insulin to smooth out their sugar control.
7. Diabetic retinopathy:
- occurs more commonly in patients with fasting blood sugars 200 mg% or greater.
 - has no effective treatment.
 - requires specialized equipment and expertise for its detection.
 - rarely occurs in patients over 50.
 - all of the above.
8. The juvenile diabetic patient:
- usually requires initial specialized care and education.
 - should ideally be cared for by a family practitioner/specialist team.
 - usually benefits from a diabetes camp experience.
 - should not receive oral hypoglycemic agents.
 - all of the above.
9. Regarding the relationship between control of blood sugar and the development of complications, which of the following statements is **not** true:
- The level of blood sugar control during the first five years of diabetes bears the most significant relationship to the subsequent development of retinopathy.
 - In experimental animals, good blood sugar control prevents or reverses diabetic renal lesions.
 - In studies of diabetic neuropathy in man and experimental animals, good blood sugar control improves nerve conduction.
 - Patients who have survived forty or more years of diabetes usually are severely disabled by diabetic complications.
 - There is no evidence that control of blood sugar will decrease the incidence of heart attacks in adult onset diabetes.
10. In terms of morbidity, the single most preventable complication of diabetes mellitus is:
- heart attacks.
 - peripheral vascular disease.
 - foot lesions.
 - strokes.
 - congestive heart failure.
11. Each return visit by a juvenile diabetic should include all of the following **except**:
- a careful history.
 - a funduscopy and visual acuity examination.
 - a serum creatinine or BUN.
 - a urinalysis.
 - a blood sugar.

Answer sheet for Pre-Test: (Diabetes . . .)

- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e
- a, b, c, d, e

Category 1 AMA Continuing Medical Education credit for this pre-test quiz will not be granted; results will be used for evaluation purposes only. Category 1 credit will, however, be granted for successful completion of the post-test, which will appear in the November issue of The Journal.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

Complete and clip the application form and mail it to:
Indiana University School of Medicine, Division of Post-graduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.

BRITISH BROWSINGS

DUKE H. BAKER, M.D.
Indianapolis



The Diagnostic Process

Computerised Tomography

The BRITISH MEDICAL JOURNAL recently published an article from the Division of Neurosurgery, Institute of Neurological Sciences, Glasgow. The cases reviewed consisted of those patients who underwent computerised axial tomography (EMI scan) because an intracranial haematoma was suspected on clinical grounds. The purpose of the investigation was to determine how reliably surgeons responsible for the emergency management of head-injured patients interpreted scans obtained in routine clinical practice.

One participating neurosurgeon reviewed the patient records to determine which were found to have had a haematoma and which did not. The scans of 100 patients were selected for review by two other participants. Half of the scans were of patients in whom a supratentorial haematoma had been subsequently verified. The remainder were of patients classified as "diffuse brain damage." None of the latter required intracranial surgery and in nine fatal cases no haematoma was found during necropsy. Scans from three patients with diffuse damage were excluded on technical grounds leaving ninety-seven scans for final review.

The scans were reviewed independently by the two examiners and without knowledge of the patient's clinical features. The two neurosurgeons agreed about the presence or absence of a significant haematoma on the scan in all but two cases. Surgeon A was confident that a haematoma was present in one patient, but his colleague was uncertain. Surgeon B was confident that there was no haematoma in another patient, while A was uncertain. To arrive at a combined assessment the confident surgeon's view was recorded in both of these cases. Comparison with the final diagnosis shows that the confident surgeon's interpretation was correct in both cases, the combined opinion of the two surgeons giving neither false-positive nor false-negative results.

In their discussion, the authors suggest that prior reports on interpretation of scans could have been biased by knowing the patient's clinical details, and an unduly optimistic appraisal of the value of the EMI

scan in head injury might have resulted. About their own work, the authors state, "Our study indicates, however, that the EMI scan is indeed reliable for determining whether or not a patient with a head injury has a significant space-occupying lesion. There was an extremely close correspondence between the independent assessments of two neurosurgeons and an exact agreement between their combined opinions and the final diagnosis."²

Scanning Techniques

The use of the newer scanning procedures, such as ultrasound and computerised tomography, has had an important influence on the diagnosis and management of patients in hospital practice. As to which of these diagnostic modes should be used in a particular patient, certain general principles and guidelines are emerging.

In an article from the Division of Radiology, Northwick Park Hospital, Harrow, the authors outline and discuss some of the factors that should be considered in choosing between ultrasonography, computerised tomography, and isotope scanning. These factors include availability, cost, the type of equipment, the expertise of the medical and technical staff, and the inherent capabilities of the system to answer the specific question required for the management of the patient.

In discussing the issue of diagnostic sequence, the authors say that "the investigator must ask a specific question relevant to the patient's condition and then decide which method is best suited to answering that question. The more specific the question asked, the more accurate and relevant the answer is likely to be." The authors continue, "Scanning techniques can, by and large, not answer a question such as 'Why so wan and pale, fair maid?' but can give an answer to, 'What is the size, shape, and position of a mass in the pancreas and is it solid or cystic?'"

It is suggested that the total process of diagnosis proceeds from the general to the specific and that a stepwise methodical approach is preferable with in-

vestigations proceeding from the least invasive or traumatic, the simplest, and the cheapest method to invasive, complicated and more costly methods.

It is reassuring that as a summary statement in this article the writers comment that even with these new diagnostic aids "there is still no substitute for good history taking and a thorough physical examination."¹

Ultrasound

In an article from the Angiology Research Group, Irish Foundation for Human Development, Dublin, the authors comment about the wide use of pulsed-echo ultrasound in obstetric practice to assess fetal growth, diagnose multiple pregnancy, and determine placental position, and that during these examinations the umbilical cord is often visible. Additionally, the authors point out that continuous-beam Doppler-shift ultrasound is used for observing blood velocity in arteries and veins. By combining these two techniques they were able to monitor the circulation in the umbilical vessels transcutaneously from 12 weeks' gestation to

full term. The investigators reported the method was successful in each of 20 patients examined and was suitable for outpatient use. They felt that the method should be useful in assessing such conditions as pre-eclampsia and intrauterine growth retardation.³

REFERENCES

1. Kreel, L, Meire, HB: The diagnostic process: A comparison of scanning techniques. *Brit. Med. J.* 2:809-811, 1977.
2. Galbraith, S, Teasdale, G, Blaiklock, C: Computerised tomography of acute traumatic intracranial haematoma: Reliability of neurosurgeons' interpretations. *Brit. Med. J.* 2:1371-1373, 1976.
3. FitzGerald, DE, Drumm, JE: Noninvasive measurement of human fetal circulation using ultrasound: A new method. *Brit. Med. J.* 2:1450-1451, 1977.



MALPRACTICE INSURANCE AVAILABLE

Owned by
PHYSICIANS

Operated by
PHYSICIANS

For the protection of
PHYSICIANS

P&S LI

Physicians & Surgeons Liability Insurance Co., Inc.
800 MacArthur Boulevard / Munster, Indiana 46321
219 836-2288



THE SCALPEL AND THE PEN

Francois Rabelais, 1483-1553

Priest, Doctor, Humanist Philosopher

RODNEY A. MANNION, M.D.
LaPorte

*"While you live, tell the truth and
shame the devil!"—*

HENRY IV, SHAKESPEARE

*"My friends, who are about to read
this book,*

*Please rid yourselves of every pre-
dilection;*

*You'll find no scandal, if you do not
look,*

For it contains no evil or infection.

*True, you'll discover, upon close in-
spection,*

*It teaches little, except how to laugh:
The best of arguments; the rest is
chaff,*

*Viewing the grief that threatens your
brief span;*

*For smiles, not tears, make the better
autograph,*

*Because to laugh is natural to
man!"—*

BOOK FIRST . . . THE GREAT GARGANTUA, RABELAIS

"Thank you for nothing."—

DON QUIXOTE DE LA MANCHA, CERVANTES

THE ITALIAN WRITER, Petrarch, living near the Papacy when it was at Avignon, initiated the new learning or Renaissance of the old learning, in the mid-14th Century. He straddled the medieval and early Renaissance Ages. Like Francois Rabelais, who existed in Europe a full hundred years later, he took clerical orders as was frequently customary in the Middle Ages. To understand Rabelais it is necessary to know the age in which he lived, his contemporary intellectuals and the so-called humanist philosophy which is at the core of his contribution to letters, and finally to be rid of the notion that he was only a writer of dirty stories.

His scatological stories are a thin disguise for ridicule and social irony and sarcasm for the civilization at the time in which he lived. His contemporary humanists include the English martyr, Sir Thomas (later Saint Thomas) More, the Dutch priest-writer Erasmus and the French writer, Budé. These men, as disparate as they indeed were, were the vanguard of modernity in the 16th Century and the heirs of a movement begun by Italians a century previously.

The philosophy of the Middle Ages was called Scholastic, and it attempted to put man in an acceptable relation to both nature and revealed scriptural truths. Thomas Aquinas was its greatest brain and proponent. The Renaissance philosophy was called Humanistic and

it placed man at the center of the universe and adapted the Greek and Roman ideals with civilized Christianity and the laws of nature as these were perceived at that time. This concept lasted for four centuries. It was the guiding principle behind the American Founding Fathers and is beautifully defined in the beginning paragraphs of the Declaration of Independence of Thomas Jefferson. Only with the advent of the interpretations of philosophy of the elitists, such as the sincerely motivated Fredrich Nietzsche, would humanism be seriously threatened. It can probably be fairly stated that, in the modern world, the democratic western world stands squarely behind humanism while totalitarianism is Nietzsche-oriented.

Rabelais was born in Poitou, the son of a well-to-do landowner and lawyer. The details of his life are indistinct after almost five centuries but it seems he studied law and then became a Franciscan novice in 1501. He eventually took Holy Orders as a Brown Friar and this pre-supposes a knowledge of Duns Scotus and Bonaventura, both prominent Franciscan theologians. It is certain that he was very well schooled in Latin and Greek. The Greek books of Rabelais and his humanist associates were temporarily confiscated by clerical authorities in 1524.

So Rabelais found himself a Greek scholar and a priest. He left the Franciscan order for the Benedictine and studied medicine in their Hotel Saint-Denis in Paris. Then he pursued further studies at Montpellier, and published translations of Hippocrates "Aphorisms" and Galen's "Ars parva." As a physician it is said that he followed classical models closely and included Avicenna's teaching in his methods. He practiced medicine at Sorbonne and was appointed physician at the Hotel Dieu in Lyons. About this time he fathered three illegitimate children and is known also to have written to that leading humanist of the time, Erasmus.

But what of the forces extant in the 16th Century which led to such diverse personalities as Rabelais, More and Erasmus espousing rebellious concepts? Briefly, these included the recapture of Constantinople with an influx of Eastern culture; the invention of printing and a common Latin intellectual language (Utopia was written in Latin); the invention or re-

discovery of gunpowder; the finding of an original Greek classical manuscript and its translation; and finally, and possibly most important, the discovery of the New World. This was indeed an age for innovative thinkers and in the field of French belles lettres Rabelais, the would-be monk, was a pre-eminent pioneer. He is said to have originated modern French literature.

There were actually two great works of Rabelais that are of interest today. Although he created that founding father of the Paul Bunyans and Baron Munchausens of the Western World, the most heroic Gargantua in 1535, he published the story of Gargantua's son, Pantagruel, in 1532. This book is now usually read second. There was an unprecedented drought in France at the time and the name Pantagruel is lifted from that of the little devil in mystery plays who would cast salt into the mouth to incite great thirst, the idea being to burlesque the notion of the hard drinking,



lusty life. Even today the reader can almost laugh aloud at Rabelais' comic sense, as when the thirsty ones drink an especially lush fruit and have a peculiar swelling of the various parts of the body. Some get a large belly, some huge noses while others get enlargement in that member, as he says, known as "nature's workman." These last are so long as to be able to be wrapped around their bodies as a

belt or girdle. Then he goes on “. . . and if it happened that the member was in form . . . you would have said, upon seeing these chaps, that they must be soldiers with lances at rest ready to joust with the dummy. Their race is lost, as women tell us; for these latter are continually lamenting the fact that *‘There are no more of those big ones, etc.’* You know the rest of the song.”

This is a deliciously Rabelaisian sentiment and apparently the entire words of that barrack room song are extant today. The whole narrative is filled with recurrences of this sort of nonsense but is usually directed to the abus-



es of society in his own age, especially the debased clergy, avaricious and hypocritical lawyers and functionaries, and the whole plethora of degenerate establishment persons. Rabelais retained some loyalty to the Franciscans—his Frere Jean, the picture of a dirty, lustful monk, was in his description, a Benedictine.

It is interesting to compare the very proper English lawyer and statesman, Sir Thomas More, with the witty and iconoclastic Frenchman, Master Francois Rabelais. Both were leading the new intellectual freedom. More was martyred for adhering to the Old Faith in 1535 (by Henry VIII, Tudor, of England) while Rabelais' books were being expunged and suppressed in France about the same time

by clerical conservatives at the Sorbonne. Gargantua and Pantagruel were, in Rabelais' stories, natives of that imaginary land called Utopia, invented by Sir Thomas. More's masterpiece was written in 1516 and 1517 and had a European vogue at the time when Rabelais was yet a student. Utopia, written in Latin, means "no where" in the Greek.

More was canonized by the Catholic Church 400 years after his death but no such accolade is likely to ascend to the sprightly and sarcastic French monk. He is more likely to have been deified, and not by the Church, but by the freethinkers of the Age of Reason such as Voltaire and even our own Ben Franklin or Tom Jefferson. And yet they both—the English statesman and the French priest—in their separate ways spoke for the dignity of man and his central position as the keystone of civilization.

Oh, if we had but a few of their mettle in the totalitarian world today or, it might be said, in our own so-called free world, for all of that! To quote from a recent commentary of "Utopia": ". . . Francois Rabelais made Gargantua a citizen of . . . (Utopia). Like More, Rabelais mingles jest and earnest, describes strange lands with remarkable customs, and devises a community dedicated to the rational pursuit of happiness. He does these things in his own way . . . and it is a very different way from More's . . . yet Rabelais owed more to More than to any other of his contemporaries."

Rabelais describes the "Abbey Theleme," situated in an actual part of his beloved French countryside and organized as a natural monastery, as it were, where the virtues were not poverty, celibacy and obedience but the "good life," marriage and good order, as a normal by-product of education. All so liberal and so French! More's Utopia is an island far distant from Europe and can in some ways be seen to pre-figure Dean Swift's "Gulliver" and Defoe's "Robinson Crusoe"—this all so English in its own way.

In the second book of Pantagruel is the most famous letter of Gargantua to Pantagruel where he defines, in the manner of Chesterfield to his son, the course of study, the mode of belief and the comportment desired of Pantagruel by his father. This is a celebrated pas-

sage because it outlines “. . . the program of encyclopedic instruction which he (Rabelais) looks upon as suited to every person called upon to occupy an elevated part in society . . .” It is to fit the young Pantagruel for an active and not a cloistered life. Gargantua makes this telling statement: “My own conduct has been, thanks to the aid of divine grace—not, I confess, without sin, for we are all sinners, and must be continually beseeching God to efface our sins—but at least without reproach.”

Philosophically, Rabelais at first espoused the cause of the reformationists as he had good reason to do, but it must be said that his feeling for man's dignity went beyond sectarian belief, and he was repelled by the then prevalent doctrine of predestination. After all, having railed against the overweening authoritarianism of the Catholic Church, he was little likely to embrace the idea of a more overpowering and impersonal Deity who would or could overlook an honest sinner who tried to live as Gargantua has it: “. . . without reproach.”

In his way Rabelais was, as Erasmus said of Thomas More, also a “man for all seasons.”



BIBLIOGRAPHY

Encyclopedia Britannica, 15:345-348, 1974.

The Portable Rabelais, by Samuel Putnam, The Viking Press, July 1946.

Twentieth Century Interpretations of Utopia, Edited by William Nelson, Prentice Hall, 1968.

Utopia, by Sir Thomas More, translated by Raphe Robynson, Cambridge, 1956.



McClain Car Leasing, Inc.

1745 Brown St., Anderson, Ind.

Phone 317/642-0261

Specializing in Professional Car Leasing

ALL MAKES AND MODELS AVAILABLE

We are proud to offer a Leasing Plan approved by ISMA

BOOK REVIEWS



Neuro-Orthopedic Screening in Infancy— Schedules, Examinations and Findings

R. Bernbeck and A. Sinios, translated by Klaus Eckstein. Copyright 1978, Urban and Schwarzenberg, 7 E. Redwood St., Baltimore, Md. 21202. \$13.50.

The authors herein attempt to provide for their colleagues "guidelines and practical recommendations for the assessment of skeletal and neuromotor findings" in infancy. They offer 31 pages of text, 40 pages of outlined tabulations and 46 pages of photos and drawings toward that purpose.

But the topics chosen for the text are highly selective while of uneven importance. The terms used and their discussions are variously confusing, redundant and ambiguous.

The many pages of tables make for much repetition and far too many inconsistencies. The tabulated "leading symptoms" are really signs or diagnoses. The "leading syndromes" are highly selective concoctions, very inadequately discussed and defined. There are even editorial insertions in the presumably objective listings. A short example of the poor outline form employed throughout can be seen on page 46:

"Clinical Picture of the Dislocated Hip"

A. Hereditary factors.

1. Family heredity factor—

Also later shallow acetabulum—steep hip coxarthrosis.

2. Sex—

Girls 4 to 5 times as frequently affected as boys.

3. Birth position—

In case of breech position, dislocation 10 times more frequent than in case of occipital positions.

4. Birth sequence—

Twice as frequent in case of first-born children.

5. Uterus anomalies—

e.g., bicornuate uterus, fibroids, lack of amniotic liquid.

6. Multiple births—

In fact, the deficiencies of the authors' outline form are most apparent when one compares all

other tables with the included one modified from the diagram used at University Children's Hospital in Zurich (page 76).

This reviewer found the photos interesting but often irrelevant to a book of screening exams of infancy. Included are photos and drawings of children of all ages up to 12 years, exhibiting diseases and deformities not encountered or preventable in infancy.

The proofreader allowed 11 typographical misspellings; nine significant words were incorrect or omitted entirely; and other bothersome errors cropped up. On page 5 hypertonía was used, instead of hypotonia, and on page 71 hypothyroidism became hyperthyroidism and our old friend intercranial raised its ugly heads. The translation was adequate and even nostalgic to my Cincinnati ear with the extra and interestingly placed adjectives and adverbs like "already."

The author's avowed intention was a good one. More infants should be assessed more carefully and more often for defects in neurologic and orthopedic structure and function. The authors' personal pet policies seemed to get in their way. Much space is devoted to such concepts as "poorly developed connective tissue," "infants nursed in prone position" and subluxation and predislocation of the hip. The opinions expressed or implied on such subjects are given such importance as to obscure what is worthwhile in the book. The book can be recommended only for those interested in the background of such opinions. Far better guidance on neuro-orthopedic screening in infancy is available in standard specialty text books and journals.

THOMAS J. CONWAY, M.D.
Pediatrician
Terre Haute

You can spend
your holidays at a
luxury resort.
Or stay home.
Or both.



The Pointe on Lake Monroe. Just 65 miles from Indianapolis, 10 miles from Bloomington. A world of residential and recreational pleasure that can be the beginning of a lifetime vacation.

A world of holiday and permanent homes overlooking 22,000 acres of watery beauty, surrounded by the hills and woodlands of Hoosier National Forest. On the lake — a yacht club and marina, beaches, fishing, dining, swimming and complete resort facilities. Within The Pointe itself — one of the state's most interesting and challenging PGA championship golf courses, swimming pool, pro-calibre tennis courts, playgrounds and gourmet dining and conviviality in the clubhouse's restaurant, lounge and party rooms.

And a selection of lifestyles to suit every possible family's needs. Comfortable one-bedroom vacation homes to spacious, three-bedroom family homes. From as little as \$29,990 up to \$79,990. And virtually every size, design and price in between.

See it for yourself. Drive out I-465 to SR-37 South to the Harrodsburg exit and follow the signs. Or call collect (812) 824-7022. Models are open 10 till 7 daily. Discover the vacation you can commute to every day.



The Pointe
on Lake Monroe

FUTURE FILE

Ear Disease Symposium

A symposium on "Ear Disease and the Primary Care Physician" will be conducted at Community Hospital in Indianapolis Oct. 21. Offering eight AMA Category 1 credit hours, subjects will include basic anatomy and physiology of the ear, basic office audiometry, electro-nystagmography and polytomography of the temporal bone, otitis media, pediatric otology, facial palsy, sudden hearing loss, the dizzy patient, otosclerosis, systemic disease in the ear and tumors of the ear.

Fee for the course is \$75. For more information, contact the Wright Institute of Otolaryngology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis 46219, phone (317) 353-5679.

Annual Newborn Symposium

The Department of Pediatrics, University of Louisville School of Medicine, will present its 12th annual Newborn Symposium, Nov. 9-10, at the Health Sciences Center Auditorium, Abraham Flexner Way, Louisville.

For information write Dr. Billy F. Andrews, Professor and Chairman, Department of Pediatrics, University of Louisville School of Medicine Health Sciences Center, P.O. Box 35260, Louisville, Ky. 40232.

Symposium on Malnutrition Offered

The Methodist Hospital of Indianapolis will conduct a symposium entitled "Diagnosis and Treatment of Malnutrition" on Nov. 15 in Wile Hall, immediately adjacent to the hospital. Registration fee is \$25. The program is approved for 8 hours credit by the AMA and 8 hours elective credit by the AAFP.

Indiana University CME Offerings

Nov. 1: Primary Care of the Hand (Indianapolis);
Nov. 1: Psychiatry for Primary Care Physicians (Kokomo);

Nov. 8-9: Neonatology for the Pediatrician (Indianapolis);

Nov. 10: Neurology Update (Indianapolis);

Nov. 18: Contact Lens (Indianapolis);

Nov. 30: Psychotic vs. Non-Psychotic Behavioral Disorders (Richmond);

Dec. 6: Office Orthopedics (Indianapolis);

Dec. 13-14: Asthma and Related Diseases (Indianapolis).

For information, write or call the Indiana University School of Medicine, Division of Postgraduate Medical Education, 1100 W. Michigan St., Indianapolis 46202. (317) 264-8353.

Child Protection Symposium

The ninth National Symposium on Child Protection will be held Nov. 26-29 at the Americana Hotel in Miami, Fla. For copies of the program and registration forms, write The American Humane Association, P.O. Box 2788, Denver, Colo. 80201.

Michigan CME Offerings

The following courses are sponsored by the University of Michigan Medical School and meet criteria for Category 1 credit. For further information, contact the university's Department of Postgraduate Medicine and Health Professions Education, The Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48109.

Nov. 13-14: Oncology-Hematology, for primary care physicians;

Nov. 15-16: Mammography for Radiologic Technologists;

Nov. 17-18: Medical-Surgical Pediatrics, for pediatricians and surgeons;

Nov. 28-30: Diagnosis and Treatment of Arrhythmias, for internists;

Dec. 1: Care of the Burned Patient, for nurses and therapists;

Dec. 5: Continuing Pathology.

Kentucky CME Courses

Fiberoptic Bronchoscopy: A Workshop, Nov. 3-4 and Dec. 1-2, \$300, 13 hours credit;

Cancer and Medicine 1978, Nov. 16-18, \$90, 13 hours credit.

For information, contact Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington 40506. (606) 233-5161.

Pediatric Dermatology Seminar

The sixth annual Pediatric Dermatology Seminar will be held in Darwin's Galapagos Islands, Feb. 17-25, aboard the M/V Buccaneer, a luxury ship.

Daily lectures and discussions will be led by Dr. Guinter Kahn of Miami Beach. For more information about the seminar, which costs \$150, contact Dr. Kahn at 16800 N.W. 2nd Ave., No. Miami Beach, Fla. 33169.

Clinical Immunology Symposium

"Clinical Immunology for the Practicing Physician" is the subject of a symposium sponsored by the Methodist Hospital Graduate Medical Center of Indianapolis on Nov. 10-11 at the Rodeway Inn Airport. The registration fee is \$150. Program is approved for 14 credit hours with the AMA and the AAFP.

Hair Transplant Symposium

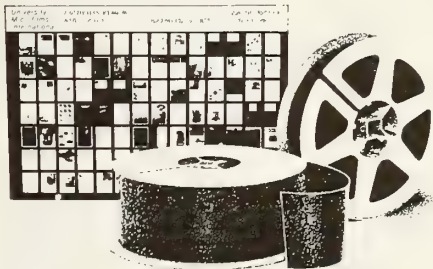
The annual hair transplant symposium and workshop will be held in Hot Springs, Ark., Jan. 25-27, 1979. It is sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, Inc., and endorsed by the American Society for Dermatologic Surgery. Registration fee is \$720. For further information, contact Dr. D. B. Stough, III, Program Director, Doctors Park, Hot Springs, Ark. 71901.

Illinois CME Symposia

Symposia sponsored by Southern Illinois University School of Medicine include the following. For more information, write the university at P.O. Box 3926, Springfield, Ill. 62708.

- Oct. 5: Diabetes Mellitus (4 hours—Mt. Vernon).
- Oct. 7: Neurology Update (4 hours—Pittsfield).
- Oct. 19-21: Annual Family Practice Symposium (Springfield).
- Oct. 28: Annual Medical Photography Workshop (6 hours—Springfield).
- Nov. 4: Annual Weber Medical Clinic (4 hours—Olney).
- Nov. 4: Blood Gases, Electrolyte Imbalance, Hyperalimentation (4 hours—Highland).
- Nov. 8: Chronic Obstructive Pulmonary Disease (4 hours—Harrisburg).
- Nov. 9: Rheumatology and Joint Reconstruction (4 hours—Quincy).
- Nov. 15: Spinal Problems (4 hours—Belleville).
- Nov. 16: OB/GYN in General Practice (4 hours—Mt. Vernon).
- Nov. 30: Respiratory Disease (4 hours—Jacksonville).
- Dec. 7: Jaundice (4 hours—DuQuoin).
- Dec. 14: Office Psychiatry (3 hours—Effingham).

this publication
is available in
microform



Please send me additional information.
University Microfilms International

300 North Zeeb Road 18 Bedford Row
Dept. P.R. Dept. P.R.
Ann Arbor, MI 48106 London, WC1R 4EJ
U.S.A. England

Name _____
Institution _____
Street _____
City _____
State _____ Zip _____

Get

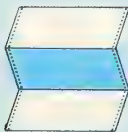


Time and time again, Medical Data Systems® users report: (1) substantial reductions in outstanding accounts receivable, (2) accelerated cash flow, (3) elimination of missing charges, and (4) faster turn around on third-party claims. Data processing services are more than fancy reports. MDS can be the difference between getting paid and not getting paid. And that's a good business basic.

S-Tek Computer Services —
The Data Processing Tailors

MEDICAL DATA SYSTEMS®

Call or write our Sales
Department for more information.



**S-Tek
COMPUTER SERVICES, INC.**

P.O. BOX 328 TERRE HAUTE, IN 47808 812-232-1385

Medical Data Systems®, a registered
trademark of S-Tek Computer Services Inc.

From The Journal 50 Years Ago

A UNITED STATES Public Health bulletin, in speaking of the spread of contagion, makes a point that is well worth widespread dissemination among mothers when it says, "Children should be taught that there are 10 objects which constantly carry contagious diseases from one person to another, and that these 10 dangerous objects are nothing more and nothing less than the 10 fingers." For years we have been telling children that if they will keep their fingers out of their mouths, noses, eyes and ears, they will be healthier, and that in consequence doctors will have fewer patients and much less to do.

WE HAVE RECEIVED several circular letters from a commercially inclined physician who says that for the sum of \$5 he is furnishing the very latest information concerning high blood pressure and its cure. The conscientious and ethical physician feels that he owes it to the profession, and to the public as well, to donate any new or important discoveries or developments concerning the cause and cure of disease. In other words, he does not ask to be recompensed at so much per person for information that may be of value in the treat-

ment of disease. We hope that no Indiana physicians have been foolish enough to send \$5 to anyone in the hope of getting a cure for high blood pressure.

HOW OFTEN IS THE PHYSICIAN asked to refrain from telling his patient the exact nature of the ailment which brings the patient to the physician for attention. Altogether too often the physician complies with the request, and always to his own detriment as well as to the detriment of the patient. A physician should remember that he has his own interests as well as the interests of the patient at stake. If he desires to avoid being branded as either an ignoramus or a knave, he will be honest in expressing an opinion, and at all times he must remember that the patient eventually will find out the truth, so why shouldn't it be given first as well as last if due consideration is given to the tactfulness with which the information is presented. Osler has said that "we are criminal participants if we refuse to tell the patient exactly the nature of his trouble," and we believe in that dictum.

JISMA, October 1928

Low Sodium Diet

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

The public at large usually speaks of a "no salt diet" or sometimes of a "low salt diet" when their intake of sodium is restricted. Many physicians speak of a "low salt diet" or write orders for a "low salt diet." Look at the order sheets in the charts at your hospital if you want to check this statement.

We recognize that it is impossible to exclude sodium chloride entirely from the diet, and therefore a "low sodium diet" is a more accurate term than a "no sodium diet."

But we should say "low sodium diet" rather than "low salt diet." There are many salts around us; there are many combinations of bases and acids to produce salts, and the word "salt" in medical or scientific terms is non-specific.

Further, the amount of restriction, say a 2 to 4

gram sodium diet per day, indicates the amount of sodium only. If one speaks of a "low salt diet" of 2 to 4 grams a day, he is including the chloride portion of the sodium chloride, according to the thinking of some people, and saying or writing "salt" instead of "sodium" doesn't help to clear the confusion. Fortunately, most dietitians recognize that a 2 to 4 gram sodium intake has been ordered, and they calculate the sodium intake only when working with such a diet.

But it helps to be clear and accurate by saying "low sodium diet" rather than a "low salt diet."

The word "salt" is probably used so widely because it is short—one syllable long, and we prefer short words in the English language.

But I think we should use the term "low sodium diet." What do you think?

NEWS NOTES

CHAMPUS Contract Changes Hands

ISMA hasn't had the CHAMPUS contract since early 1977, but the headquarters still receives CHAMPUS claims. When ISMA quit handling the contract, it went to Wisconsin Physician Service. Now, as of Sept. 15, the handler for the Civilian Health and Medical Program of the Uniformed Services for Indiana and Kentucky—home of about 73,000 CHAMPUS beneficiaries—is Blue Cross of Southwestern Virginia, P.O. Box 13828, Roanoke, Va. 24034, Tel: 1-800-542-5829. According to Gerald M. Kirk, director of Provider Relations for the non-profit organization, their current turn-around time on claims averages 10-21 days. They also handle CHAMPUS programs for the District of Columbia, North Carolina, South Carolina and Virginia. CHAMPUS beneficiaries are dependents of active duty military personnel, and military retirees and their dependents; dependents of totally and permanently disabled veterans are also eligible.

AMA Lowers Dues for New Physicians

The AMA has voted a 50%, one-year cut in membership dues for physicians first entering practice. The cut means physicians will be paying \$125 rather than the regular \$250 during their first year of practice. A membership gain of almost 5,000 is expected within the next five years as a result of the action. A survey had shown that the \$250 dues, rather than any lack of awareness of AMA activities, had been a major obstacle to new-practitioner membership.

Lilly Acquires Cardiac Pacemakers, Inc.

Eli Lilly and Company announces the acquisition of Cardiac Pacemakers, Inc. Cardiac Pacemakers distributes its products worldwide and has its domestic headquarters in St. Paul, Minn. The transaction is subject to approval by the boards of directors and approval by the Securities and Exchange Commission.



Roche Pamphlets on Public Issues

Roche Laboratories has enlarged its series of public issues pamphlets and offers to furnish the booklets, which are written for the public, to physicians for waiting room distribution. The first three in the series were announced in the July 1978 issue of The Journal. Numbers four through eight are titled as follows: 4. Human Volunteers in Drug Experimentation. 5. The U.S. Economic System. 6. Energy Conservation: Everyone's Concern. 7. Quality Control at Hoffmann-La Roche. 8. The Importance of Trademarks to the Consumer. Any of the pamphlets or all of them may be obtained free of charge by addressing The Journal.

Physician Recognition Awards

The following Indiana physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Aldred, Allen W., Ft. Wayne
Bawab, M. Samir, South Bend
Bishop, Michael Daryl, Bloomington
Boen, Bradley Nelson, Indianapolis
Cockerill, Edward Meeks, Indianapolis
Deppe, James Timothy, Terre Haute
Desai, Remesh, Rockville
Dones, Antonio Braganza, Ft. Wayne
Edwards, Joshua L., Indianapolis

Grainger, James Lewis, South Bend
Hoff, Kenneth Eugene, Rochester
Kimbrough, Robert F., Ft. Wayne
Kinasiewicz, Leon E., Crown Point
Loh, Hwei-Ya Chang, Gary
Minick, Linus J., Churubusco
Peterson, Deward D., Terre Haute
Remich, Antone Charles, Hammond
Roberts, Warren Charles, Indianapolis
Rudicel, Max Hurd, Muncie

Russ, Mitchell Allen, Indianapolis
Sala, Walter Rudolph, Merrillville
Searcy, Linda Marie, West Lafayette
Spurlock, Fae Hedrick, Lafayette
Steffy, Ralph Maurice, Portland
Voskuhl, William Louis, Charlestown
Wahle, William Montgomery, Indianapolis
Yingling, Robert James, Indianapolis
Zivnuska, Frederick R., Evansville

Medic Alert Foundation International

Medic Alert's lifesaving system of protection is available for a one time, lifetime basic membership fee of \$10.

The system includes a metallic alerting device—a bracelet or necklace—with Medic Alert on one side and the medical problem or problems engraved on the other side, together with a wallet card. The card is dated and is renewed annually to ensure that personnel who are aiding the wearer will know the data is up-to-date.

The telephone number of the Emergency Answering Service is engraved on the metallic device and is printed on the card. This service will receive a collect telephone call from anywhere in the world for inquiries as to detailed medical history.

In a recent 12-month period, more than 2,000 members reported Medic Alert had contributed to saving their lives. Foundation membership exceeds 1 million. All persons with hidden or special medical problems that cannot be easily seen or recognized are invited to join.

The Foundation is non-profit, charitable and tax-exempt. The address is P.O. Box 1009, Turlock, California, 95380. The regional office is at 840 N. Lake Shore Drive, Chicago, Ill. 60611, tel: (312) 645-8344.

JOURNAL Abandons Copyright

Effective with this issue of The Journal, a long-standing policy of obtaining copyright registration for each issue (heretofore issued by the Copyright Office in accordance with the provisions of section 410(a) of title 17, United States Code) is being abandoned. Instead, The Journal will allow the copyright to remain with the author or artist, and it will be assumed that submission of material—to include scientific articles—is a waiver authorizing this procedure. The plan was recently approved by the ISMA Board of Trustees.

Hoosier Journalist Wins Fellowship

John H. Ullmann of South Bend, at one time a journalist in Indianapolis, is one of three journalists named recipients of the Nate Haseltine Memorial Fellowships of the Council for Advancement of Science Writing for 1978-79. He will specialize in science writing at the University of Missouri School of Journalism.

Jail Project Spreads to 15 States

Accreditation standards under the AMA's Jail Health Project will be expanded to include the areas of mental health, chemical dependency and juvenile treatment. In addition, the program will be expanded from six to 15 pilot states. (Indiana was one of the original six states.) Under the project, state medical associations work with the AMA and the jails to develop an accreditation program.

AMA Film Wins Top Prize

The 22-minute AMA film "Out of Sight, Out of Mind" won the top prize in the medical sociology category at the John Muir Medical Film Festival at Walnut Creek, Calif., recently. The film examines medical care problems in jails and the progress made in solving them through the AMA Jail Health Project. The film is available on a free-loan basis to state, county and specialty medical societies. Write Audio-Visual Services, AMA Headquarters.

Film Offered to Medical Schools

A new film on the diagnosis and management of tardive dyskinesia is being offered free of charge to medical schools by Sandoz Pharmaceuticals. Early detection and prevention are important since the syndrome is irreversible and is caused by the chronic ingestion of anti-psychotic drugs. A 16mm film "Tardive Dyskinesia: Diagnosis and Treatment" is available to medical schools through the Sandoz Medical Sciences Liaison or by writing to Sandoz at East Hanover, N.J. 07936.

Cancer Corner . . .

CONTINUED FROM PAGE 980

least 70% of the cancers were localized to the breast, offering an excellent chance of cure.

Through the use of this detection technique, breast cancers now are being found at an earlier stage than ever before. Pathologists are acquiring more and more experience in the diagnosis of minimal breast cancers. Although sometimes there may be disagreement among pathologists about the exact nature of microscopic cancers, a recent review has shown only rare differences of opinion in the diagnosis of minimal breast cancer in these projects.

There are no restrictions on using mammography as a diagnostic tool for symptomatic women of any age.

For screening asymptomatic women, however, the following guidelines have been determined for mammography in the ACS/NCI projects:

- All women over the age of 50 may continue to have mammograms annually.
- Women 40 through 49 may have mammography if they, or their mothers or sisters have had breast cancer.
- Women 35 through 39 may have mammography only if they have a personal history of breast cancer.
- All women may continue to receive a clinical examination, thermography and instruction in breast self-examination.

NEWS NOTES

NHI Proposals Could Boost CPI 6%

Richard L. Leshner, president of the U.S. Chamber of Commerce, says "further government intervention into health care will only fuel inflation." He noted that Medicare, which the government estimated would cost about \$1.4 billion in its first year, had ended up costing \$3.5 billion that year—250% over estimate—and is projected to cost \$30 billion by 1980. "The same thing will happen if we enact national health insurance," he said. NHI proposals being considered by the Administration would increase expenditures for health care by at least \$16 to \$27 billion, according to a Chamber analysis. But the Medicare experience suggests that the Administration's alternatives could cost an additional \$39 to \$67 billion, boost the Consumer Price Index by as much as 6%, and cause a \$1,500 loss in average family purchasing power, according to the analysis.

Sertoman of the Year

Dr. Robert D. Arnold of Indianapolis has been named 1978 recipient of Sertoma International's Distinguished Service Award (Sertoman of the Year). Dr. Arnold, president-elect of the medical staff at Community Hospital, is a life member of the Sertoma Club and is active in the organization's activities. He is chairman of the East Indianapolis Club's new club building committee, which has helped charter 21 new Sertoma clubs in Indiana.

Chicago Museum Offers CPR Training

Free courses in cardiopulmonary resuscitation are offered to the public at the Museum of Science and Industry in Chicago by the Chicago Department of Health. The day-long training sessions are comprehensive and include a teaching film, lectures and demonstrations, and practice with manikins. The courses were first given in 1977 to personnel from police, fire and health departments and are now open to the general public.

AMA Poll Shows Physicians Still Care

Physicians still adhere to the principle of caring for all patients, regardless of ability to pay, an AMA opinion poll of physicians indicates. In fact, the poll shows most physicians continue to reduce their fees or provide free care to patients who can't pay. Until the mid-1960s, when Medicare and Medicaid legislation was enacted, 97% of all responding physicians said they care for patients without charge or at reduced fees; even now, 83.4% say they make similar concessions to patients who are poor, can't afford health insurance, and are not covered by some state or federal program. Of these, 34.4% say they bill the patient but let the bill run without pressure for payment, 30.5% say they reduce the bill, and 18.5% say they send no bill at all. The majority of physicians, 67%, were not enthusiastic about the net effect of efforts to turn every patient into a "paying patient" through various government programs.

New President for Little Red Door

Dr. Ned B. Hornback, professor and chairman of the Department of Radiation-Oncology, I.U. Medical Center, has been elected president of the Little Red Door, Marion County Cancer Society.

Model Paramedic Program?

Dr. John C. Pulcini, president of the Metropolitan Evansville Emergency Medical Services Council, says Evansville's paramedic training program may become the model emergency medical services program for Indiana. The program resulted from an agreement between all three of the city's hospitals. He said, "We've gotten our act together. We believe we have the expertise, the facilities and the manpower to make it work." Under the agreement, the hospitals are sharing their resources in developing a coordinated paramedic training program. The city is financing installation of radio equipment in a Fire Department ambulance and is providing salary incentives to city personnel who become certified paramedics. Classes began last month.

I.U. to Host Library Meeting

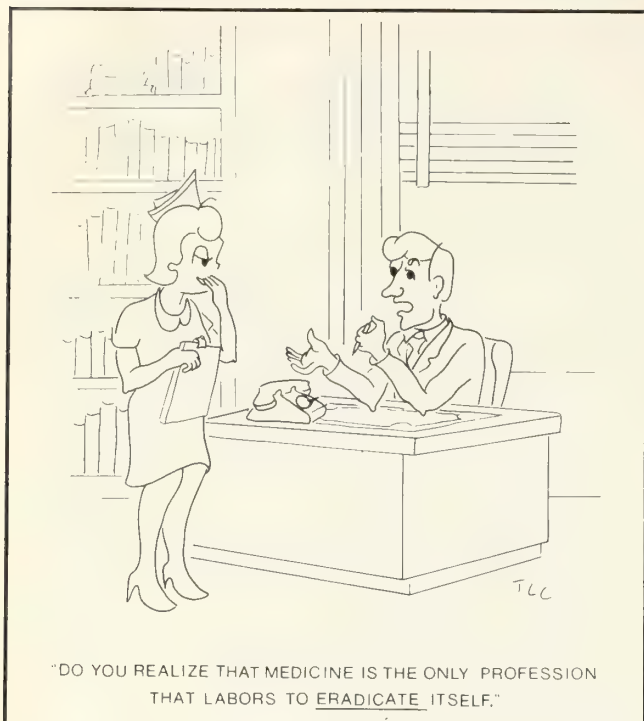
The Indiana University School of Medicine Library will be host to the Midwest Regional Group of the Medical Library Association in the spring of 1979. Health science librarians in metropolitan Indianapolis will assist in conducting the meeting.

5 Reasons Why INDIANA DOCTORS Recommend HANGER Prostheses...

1. HANGER is the oldest and largest prosthetic manufacturer in Indiana.
2. More people in Indiana wear HANGER Prostheses than any other make.
3. The HANGER organization has more employees and more certified fitters than any other prosthetic manufacturer.
4. HANGER wearers are guaranteed HANGER service and repairs at 39 HANGER offices in leading cities.
5. HANGER research is working actively on new prosthetic developments for the benefit of all amputees.

Hanger
PROSTHESES

NEWS NOTES



Named 'Teacher of the Year'

Dr. Fayez S. Tushan of Indianapolis has been named "Teacher of the Year" by the Department of Education, Community Hospital. He was cited for his contribution to the education of medical students, residents and graduate physicians. The award is a memorial for Margaret Kuhn, whose husband served on the board of directors at Community.

AMA Creates Student Business Section

The AMA house of Delegates has formally established the Student Business Session as a section of the House, renamed it the Student Business Section, and provided a representative structure for its annual and interim meetings. The new structure provides for representation of students at each medical school through one certified voting representative. The SBS governing council will be expanded from six to eight members. The new plan is expected to be implemented at the 1979 SBS annual meeting.

Elected President of Lung Association

Dr. Glen A. Ramsdell of Richmond has been elected president of the American Lung Association of Indiana. He formerly held the office of president of the Indiana Thoracic Society, which functions as a medical advisory group to the lung association.

New Face for The Hoosier Doctor's Wife

Marcia (Mrs. Gene) Laker of Fort Wayne is the new editor of *The Hoosier Doctor's Wife*, quarterly newspaper of the ISMA Auxiliary. She told her readers, "This seems a fitting time to say thank you to our editor emeritus, Jean Green, who has done 100 times over the past 25 years the task I am undertaking for the first time. Also, thank you to Pat Dimitroff for her care in detail and innovations in the 1976-77 year, and to Mary K. Stanley, who deserves a special star in her crown for being both the president of our organization and the editor of *The Hoosier Doctor's Wife* in the 1977-78 year." In announcing a new format for the newspaper, Mrs. Laker urged county auxiliary presidents to contribute news articles and photographs for publication.

Named Diplomat

Dr. Thomas P. Konicke, formerly of Chesterton, has been named a diplomate of the American Board of Family Practice. He now practices at Miami-Inspiration Hospital in Globe, Ariz.

'Primer of Brain Tumors'

A 40-page "Primer of Brain Tumors" has been published by the Association for Brain Tumor Research and will be provided without charge to brain tumor patients and their families. The booklet is written in as much lay language as possible and a glossary explains medical terms. Write Brain Tumor Research, 6232 N. Pulaski Road, Suite 200, Chicago 60646.

Heimlich Appears in Richmond

Dr. Henry J. Heimlich, creator of the Heimlich hug for dislodging food or other matter from the windpipe of a choking person, served as honorary chairman of the 1978 Wayne County Health Fair in Richmond last month. He is presently a faculty member at Xavier University in Cincinnati. Dr. Heimlich presented a talk during the fair.

INDIANA MEDICAL BUREAU

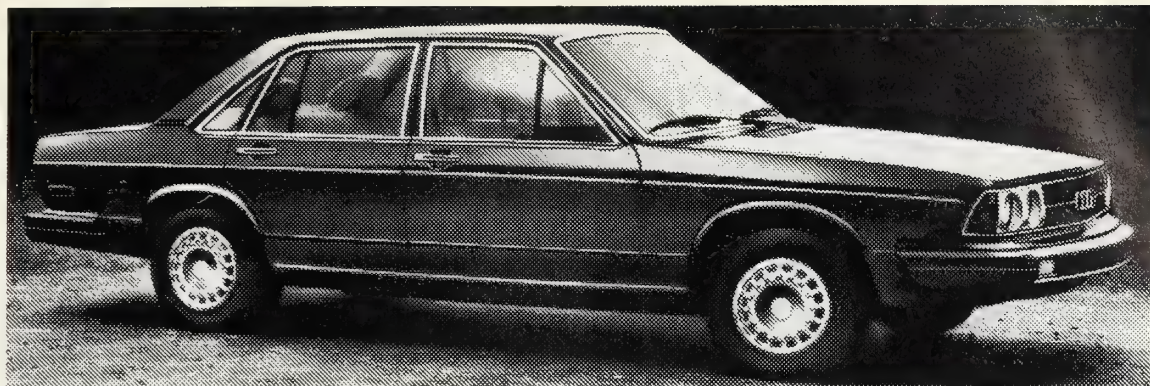
1010 East 86th St.—72 Winterton

Indianapolis 46240

844-7933

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 26th Year of Service



"IN MY FAMILY, I PICK THE CAR AND LET MY HUSBAND PICK THE COLOR."

HERMINE FINKENZELLER, AUDI 5000 STRUCTURAL ENGINEER



Isn't it usually the other way around?

Finkenzeller: Well, I suppose it's a bit unusual for a woman to be a structural engineer. But I am and it happens that my husband is not, although, he's very good at his job. I've been designing automotive components for 15 years.

How will women feel about the Audi 5000?

Finkenzeller: Good. They'll like its layout. It is probably the most intelligent 15½ feet of engineering on the road today. My colleagues developed a 5-cylinder gasoline engine that has plenty of power, yet doesn't take up unnecessary space inside, so the Audi 5000 seats five people very comfortably. Actually, it's a big car. In fact, I believe, in your country, it's the largest German luxury car for the money, less than \$9,000*.

Will men like the Audi 5000?

Finkenzeller: Men? Of course. I think they will love its power and handling. The Audi 5000 may be an elegantly conservative car but it's not sedate. With front-wheel drive, it takes corners beautifully, especially for such a big, luxurious car. People are always surprised to find out how responsive this car is. That amuses us.

Are you always this sensible?

Finkenzeller: Sensible? If you mean logical and precise, I'd say yes, when it comes to doing my work. In my profession, I have to be precise. However, if what you really want to know is whether I'm ever emotional or even romantic, perhaps you should ask my husband about that.

*Suggested 1978 retail price \$8,780. P.O.E. transp., local taxes, and dealer delivery charges, additional. Come test-drive the Audi 5000 at your local Porsche + Audi dealer.

See your nearby Audi dealer.

PHYSICIANS' DIRECTORY

INTERNAL MEDICINE

Offices for the doctors listed below are located at 3130 N. Meridian St., Indianapolis 46208; the switchboard number is 317-927-1221.

MERIDIAN MEDICAL GROUP

CARDIOLOGY

Richard M. Nay, M.D.
Warren E. Coggeshall, M.D.
Richard R. Schumacher, M.D.
William C. Elliott, M.D.

HEMATOLOGY—ONCOLOGY

Laurence H. Bates, M.D.
William M. Dugan, M.D.
James E. Schroeder, M.D.
Frank A. Workman, M.D.
Deborah S. Provisor, M.D.
Pediatrics

METABOLISM AND ENDOCRINOLOGY

William M. Holland, M.D.

GASTROENTEROLOGY

Robert D. Pickett, M.D.
B. T. Maxam, M.D.
Lee G. Jordan, M.D.
Martin P. Meisenheimer, M.D.

INTERNAL MEDICINE

Hunter A. Soper, M.D.
Douglas H. White, Jr., M.D.
Michael B. DuBois, M.D.

Nephrology

Michael P. Bubbs, M.D.
Robert L. Iverson, Jr., M.D.
Critical Care

Michael Zeckel, M.D.

Infectious Diseases

INFECTIOUS DISEASES

Thomas G. Slama, M.D.

NEUROLOGY

Norman W. Oestrike, M.D.
Charles Rehn, M.D.

NEUROSURGERY

By Appointment

Phone 925-4255

C. BASIL FAUSSET, M.D.

Neurological Surgery

1815 North Capitol Avenue

Indianapolis 46202

By appointment only

Phone 317-353-6800

BIO MEDICAL LABORATORY

5506 East 16th St., Suite 24
Indianapolis 46218

Bio-Feedback Training for Migraine and Tension Headache

KARL L. MANDERS, M.D.

JOHN S. MARKS, JR., M.D.

MALCOLM S. SNELL, M.D.

PLASTIC SURGERY

NEPHROLOGY & INTERNAL MEDICINE, INC.

Daniel J. Ahearn, M.D.

Thomas Wm. Alley, M.D., FACP

George W. Applegate, M.D.

Charles B. Carter, M.D.

William H. Dick, M.D., FACP

Theodore F. Hegeman, M.D.

Douglas F. Johnstone, M.D.

LeRoy H. King, Jr., M.D., FACP

2020 W. 86th St., #307, Indianapolis 46260 Ph: 317-844-9911
1633 N. Capitol, #722, Indianapolis 46202 Ph: 317-926-0757

Answering Service 926-3466

CLINICAL NEPHROLOGY, RENAL TRANSPLANTATION, HEMODIALYSIS, PERITONEAL DIALYSIS, HYPERTENSION, FLUID AND ELECTROLYTE IMBALANCE, CRITICAL CARE.

PLASTIC & HAND SURGERY CLINIC, INC.

1944 N. Capitol Ave.

Indianapolis 46202

"An office surgery facility"

Haroon M. Qazi, M.D.

Diplomate, American Board of Plastic Surgery

Phone: 317-923-4822

317-926-3466

HAND SURGERY

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

By appointment

Phone 317-783-1319

VIDYASAGAR S. TUMULURI, M.D., F.A.C.S., INC.

Diplomate American Board of Surgery
Acute & Reconstructive Hand Surgery
General Surgery

3530 S. Keystone, Suite 305

Indianapolis 46227

PHYSICIANS' DIRECTORY

PSYCHIATRY

JOHN H. GREIST, M.D.

Diplomate, Board of Neurology and Psychiatry

Specializing in Psychiatry

3231 North Meridian Street

Indianapolis 46208

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALCOHOLISM TREATMENT

GERALD P. JOHNSTON, M.D.
BRADLEY N. BOEN, M.D.
PAUL M. FLANAGAN, M.D.
HAROLD G. NICHOLS, M.D.

Comprehensive Alcoholism Treatment

Fairbanks Hospital
1575 Northwestern Avenue
Indianapolis, Ind. 46202

(317) 638-1574

ALLERGY

INDIANA ASTHMA & ALLERGY ASSOCIATES

Specializing in Chronic Severe Asthma
and

Adult and Pediatric Allergic Disorders

D. Duane Houser, M.D., Inc.
(317) 923-7650

and

Douglas J. Horton, M.D.
(317) 923-6990

1815 N. Capitol Avenue
Indianapolis, Indiana 46202

Diplomates, American Board
of Allergy & Immunology

Answering Service 926-3466

CARDIOLOGY

William K. Nasser, M.D. and Michael L. Smith, M.D.
are pleased to announce the addition of Cass
A. Pinkerton, M.D. for the practice of cardiology
and cardiac catheterization.

8402 Harcourt Road, Room 413
St. Vincent's Professional Building
Indianapolis — (317) 257-9316

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

OBITUARIES

Bob R. Cagle, M.D.

Dr. Cagle, 48, New Palestine's only resident physician, died July 19 at Hancock County Memorial Hospital after suffering a heart attack at his home.

A native of Brazil, Indiana, and a 1955 graduate of Indiana University School of Medicine, Dr. Cagle began practice in the Palestine area in 1958, following his discharge from the U.S. Air Force. He was on the staff

of the Hancock County Hospital, had been school doctor in the New Palestine school system, and served more than 10 years on the Southern Hancock School Corporation Health Council. He had served two terms as secretary and two as vice-president of the Hancock County Medical Society.

Ralph V. Everly, M.D.

Dr. Everly, 70, a general practitioner in Indianapolis 40 years, died Aug. 27 at his summer home in Minnesota.

Dr. Everly, who earned his medical degree in 1935 at the University of Louisville, was a former chief of staff at Methodist Hospital, Indianapolis.

He also was a former chairman of the ISMA executive committee and had been president of the Marion County Medical Society in 1956.

Dr. Everly, a World War II Army veteran, was a member of the American Academy of Family Physicians.

Stanley E. McClure, M.D.

Dr. McClure, 76, a retired Monon physician, died July 19 in White County Memorial.

He was born in Kentucky and was graduated from the University of Louisville Medical School in 1925. Prior to opening his practice in Monon, he was associated with Arnett Clinic and St. Elizabeth Hospital in Terre Haute. He served the White County community for

45 years before his retirement five years ago.

Dr. McClure was a member of the ISMA 50-Year Club, a former president of the White County Medical Society, and an honorary staff member at St. Elizabeth and Home Hospitals at Lafayette and White County Memorial Hospital.

Leonard Locke Nesbit, M.D.

Dr. Nesbit, 79, a practicing physician in Anderson for 42 years, died Aug. 4 at St. Vincent Hospital, Indianapolis.

Born in Henry, Ill., he was graduated from the Indiana University School of Medicine in 1929. He retired in 1976.

Dr. Nesbit, a senior member of the ISMA, had been a member of the staff of Community Hospital and St. John's Hickey Hospital in Anderson. During World War II he had served with the U.S. Medical Air Corps in England.

Thomas B. Pauszek, M.D.

Dr. Pauszek, 80, one of Indiana's first obstetricians, died Aug. 9 in Healthwin Hospital, South Bend.

A veteran of World War I, he practiced in South Bend for 50 years following his graduation in 1924 from the University of Michigan Medical School.

Early in his career, Dr. Pauszek, born in Dunkirk,

N.Y., had been chief resident physician of St. Joseph Hospital, Baltimore, Md. After moving to Indiana, he became a staff member of St. Joseph Hospital, South Bend. Dr. Pauszek, a founding fellow of the Society of Obstetrics and Gynecology, became a member of the ISMA 50-Year Club in 1974.

Sallie Tyrrell, M.D.

Dr. Tyrrell, an obstetrician and gynecologist in the Calumet region, died of a heart attack Aug. 10 in her home.

She was the wife of Dr. Thomas Tyrrell of Calumet City.

Dr. Tyrrell was a 1944 graduate of the Chicago Med-

ical School. She joined the staff of St. Margaret Hospital, Hammond, in 1946 and remained on the staff of the Department of General Practice until her death. She and her husband and brother-in-law, Dr. Joseph Tyrrell, had operated the Tyrrell Clinic since 1950.

Paul A. F. Walter, III, M.D.

Dr. Walter, 53, an Evansville physician, died Aug. 6 aboard his boat in Eddyville, Ky. A coroner's report ruled that his death was accidental, stating that he suffered a broken neck in a fall on the boat.

A 1948 graduate of Stanford University School of Medicine, Calif., Dr. Walter had been associate director

of medical services for Mead Johnson Laboratories since 1975; he joined the company in 1960.

Dr. Walter had served in the Navy as a flight surgeon during the early 1950s. He was a member of the New York Academy of Science and of the American Society for Clinical Pharmacology and Therapeutics.

COMMERCIAL ANNOUNCEMENTS

Commercial announcements are carried in The Journal as a special service to ISMA members. Only advertisements considered by publisher to be of advantage to members will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

20¢ for each word

\$4.00 minimum

Send cash with order. Average count: seven words to the line.

Address: The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

DEADLINE: Fifth day of month PRECEDING month of issue.

FULL TIME MEDICAL DIRECTOR for position in medium-sized industrial medical facility, Marion, Ind. Excellent clinic facilities; staff includes full registered nursing coverage. Previous industrial experience desirable, but not mandatory. Full corporate benefits, including malpractice insurance, company paid insurance, top notch fringe benefits. Position open immediately. Please send resume, with minimum salary requirements, in confidence to: M. Hranchook, M.D., Divisional Medical Director, Fisher Body Division, G.O., General Motors Corporation, 30001 Van Dyke Ave., Warren, Mich. 48090. Tel: (313) 575-5976.

FOR LEASE: On Vanderbilt Beach near Naples, Fla., two-bedroom, two-bath new condominium on the beach. Docking facilities available. Tel: (317) 644-6147.

TWO YOUNG GENERAL INTERNISTS seeking replacement for departing third member of group. Busy, established practice. Board certification or eligibility required. Send CV to Logan Internists, Inc., Suite A, 1201 Michigan Ave., Logansport, Ind. 46947.

X-RAY EQUIPMENT—Rocket 300 MA generator with rotating Anode starter, floor-to-ceiling tube stand, Emerald x-ray tube, high-voltage cables, tilting radiographic x-ray table. Automatic 90-second processor-Pako 14 X with darkroom shield. Family Health Care Center, 2124 E. Hanna Ave., Indianapolis 46227. Tel: (317) 787-7221.

TWO BOARD CERTIFIED FAMILY PHYSICIANS need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please send curriculum vitae to Link, Chapman & Associates, Inc., 1515 W. Truman Road, Independence, Missouri 64050, or call collect (816) 836-8200 between 9 a.m. and 4:30 p.m.

MICHIGAN CITY, INDIANA—Emergency Department Director; flexible scheduling. Excellent income—\$57,000 to \$65,000. Paid malpractice insurance. Contact T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, Missouri 63141, or call toll free 1-800-325-3982.

EMERGENCY MEDICINE: Seeking career-oriented emergency physician to complete group of four. Community hospital with 330 beds and 30,000 emergency department visits per year. Malpractice insurance provided. Fee for service compensation. Contact Paul Laudick, St. John's Hospital, 2015 Jackson St., Anderson, Ind. 46014.

OPHTHALMOLOGIST—Board certified/eligible ophthalmologist sought to associate in an established practice. Major regional medical center consisting of 43 multi-specialty physicians in northwest Ohio. Top salary and excellent fringe benefit program along with all corporate benefits. Please forward curriculum vitae, salary requirements to Box J, The Journal.

EMERGENCY DEPARTMENT DIRECTOR NEEDED—Modern community hospital with excellent work surroundings, near Cincinnati. 17,000-20,000 patient visits per year. Annual salary and benefits total from \$66,000-\$68,000. Some residency training and administrative experience helpful, but not necessary. Interested parties should call collect Dr. G. T. Bowen, M.D., Dearborn County Hospital, Lawrenceburg, Ind. 47025. (812) 538-1010.

OPPORTUNITIES FOR PHYSICIANS—There are several excellent openings among the Indiana State Hospitals at various locations throughout the State for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Candidates must be licensable in Indiana. Please reply with a copy of the c.v. to: FARABEE & ASSOCIATES, INC., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

THE INDIANA STATE DEPARTMENT OF PUBLIC WELFARE has a position available for a physician to work in a pleasant office atmosphere; no patient contact; no malpractice insurance required; an Indiana license or eligibility is required; competitive salary; regular working hours; excellent fringe benefits. Contact: Personnel Director, Indiana State Department of Public Welfare, 702 State Office Building, 100 N. Senate Ave., Indianapolis 46204. Phone: (317) 633-6403.

PHYSICIAN'S OFFICE AVAILABLE—Has been physician's office for last 8 years. Eastside, 5 minutes from St. Francis and Community Hospitals. All utilities except phone. American alarm, private parking, large waiting room. (317) 357-7657 or 357-2403.

RETIRED or physically restricted or limited practice physicians as **MEDICAL DIRECTORS** of plasma center in West Lafayette area. Call Mr. Reiland at (317) 924-6336, PLASCON, INC.

ISMA ANNUAL MEETING
October 22-25 • Clarksville



"Efficiency is the key to your practice"

Graduates of P. C. I. are thoroughly trained in the most up-to-date methods as Medical Assistants (AMA accredited) and Medical Receptionists.

PROFESSIONAL CAREERS INSTITUTE

6321 La Pas Trail, Indianapolis, IN 46268
Telephone: (317) 299-6001

Are You Moving?

If so, please send change of address to Membership Dept., ISMA, 3935 N. Meridian St., Indianapolis, IN 46208, at least six weeks before you move.

Name _____

Address _____

City _____

State _____

Zip _____

County _____

IMPORTANT — Attach mailing label from your last Journal here.

ADVERTISERS IN THIS ISSUE

October 1978

Vol. 71

No. 10

American Fletcher National Bank	998
Blue Cross-Blue Shield	949
Brown Pharmaceutical Co., Inc.	967
Burroughs Wellcome Co.	945
Crutcher Antiques	958
Dave Waite Leasing	966
Flesher, Realtor	954
General Microcomputer, Inc.	947
Giganti, Inc.	996
Hanger Prostheses	1015
Import Motors, Inc.	1017
Indiana Medical Bureau	1016
Lilly, Eli and Company, Inc.	957
McClain Car Leasing, Inc.	1007
Mead Johnson Pharmaceutical Div.	981, 982
Medical Protective Company	993
Merrell-National, Inc. ..	960, 961, 972, 973, 974
Morris Plan	974
Professional Careers Institute	1022
P & SII	1003
Purepac Pharmaceutical Co.	955
Richardson-Merrell, Inc.	952
Roche Laboratories	Covers, 950, 951
Rockwood Insurance Company	977
Smith, Kline & French	962, 988, 989
S-Tek Computer Services, Inc.	1011
The Pointe	1009
The Upjohn Company	971
Townsend, J. Russell and Associates	963
U.S. Navy	960

In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

November 1978 • Vol. 71 • No. 11

TI

INDIANA STATE MEDICAL
ASSOCIATION JOURNAL

12-78
The Library, Acquisitions Dpt.
U. of Calif., San Francisco
SAN FRANCISCO, CA 94143

LIBRARY
U. of Calif., San Francisco
SAN FRANCISCO, CA 94143

Librium... an unsurpassed

(chlordiazepoxide HCl)



More than two decades of research—including hundreds of animal studies and hundreds of clinical trials—stand behind the proven antianxiety performance of Librium.



safety record



What excited clinical researchers about Librium was its promise of effective antianxiety action within an unprecedented margin of safety. This promise continues to be fulfilled in millions of patients today— most likely including many of your own.

The highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record. Clinical experience with millions of patients indicates that the most common side effects are dose-related and thus largely avoidable. Tolerance rarely develops at recommended doses. Few cases of known toxicity have been reported. In proper dosage, Librium rarely interferes with mental acuity or produces adverse effects on the cardiovascular or respiratory system. Patients should, however, be cautioned about performing tasks requiring mental alertness, such as driving, and possible combined effects with alcohol.

- ☐ Proven antianxiety performance
- ☐ Minimal effect on mental acuity
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Librium[®]
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules

chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

WHAT'S NEW?

Hewlett Packard announces a new advanced arrhythmia monitoring system that automatically detects and warns of premonitory ventricular beats and other life-threatening arrhythmias. It has functioned in as many as 16 patients simultaneously. It relieves the CCU staff of the fatigue of visually monitoring ECG tracings. The system (HP 78225) can store VPBs and other cardiac events over a 24-hour period and then display the data on request.

* * *

Executone has a new key telephone system designed for offices with 15 to 50 phones. The system, known as Charter, provides savings and flexibility. It includes an interoffice speaker which functions without picking up the handset and without dialing. All incoming calls may be answered by one station, and referred or incoming calls may ring direct and be referred back to the attendant station if the desired station does not answer.

* * *

Riker Laboratories is introducing slow-release theophylline tablets. Theolair™ Slow-Release Tablets will be a companion product to Theolair™ Tablets and Theolair™ Liquid. For some patients the new formulation will allow *b.i.d.* dosing and reduce the peak-to-trough blood levels associated with faster release forms.

* * *

Eli Lilly has been approved for marketing Dobutrex®, a synthetic catecholamine used in treating cardiac decompensation. It augments cardiac contractility without causing any more than a mild amount of hypertension, arrhythmia or vasodilation. There is evidence that Dobutrex increases coronary perfusion and improves or maintains myocardial oxygen balance.

* * *

Johnson & Johnson is introducing "Johnson's Underpad," a 28"x30" disposable bed-linen protector for hospital use. The absorbent facing of the pad is totally laminated to the waterproof polyethylene backing, the edges are bonded. This minimizes bunching, tearing and shredding.

* * *

Narco/Air-Shields has published an 8-page, 4-color brochure which describes their family of products covering treatment in neonatal/pediatric intensive care units. The Isolette® Infant Incubator, the Infant Care System, the Transport Incubator, Series 8000 Digital Monitors, the Sensor Pad Apnea Monitor and the Phototherapy Attachment are described.

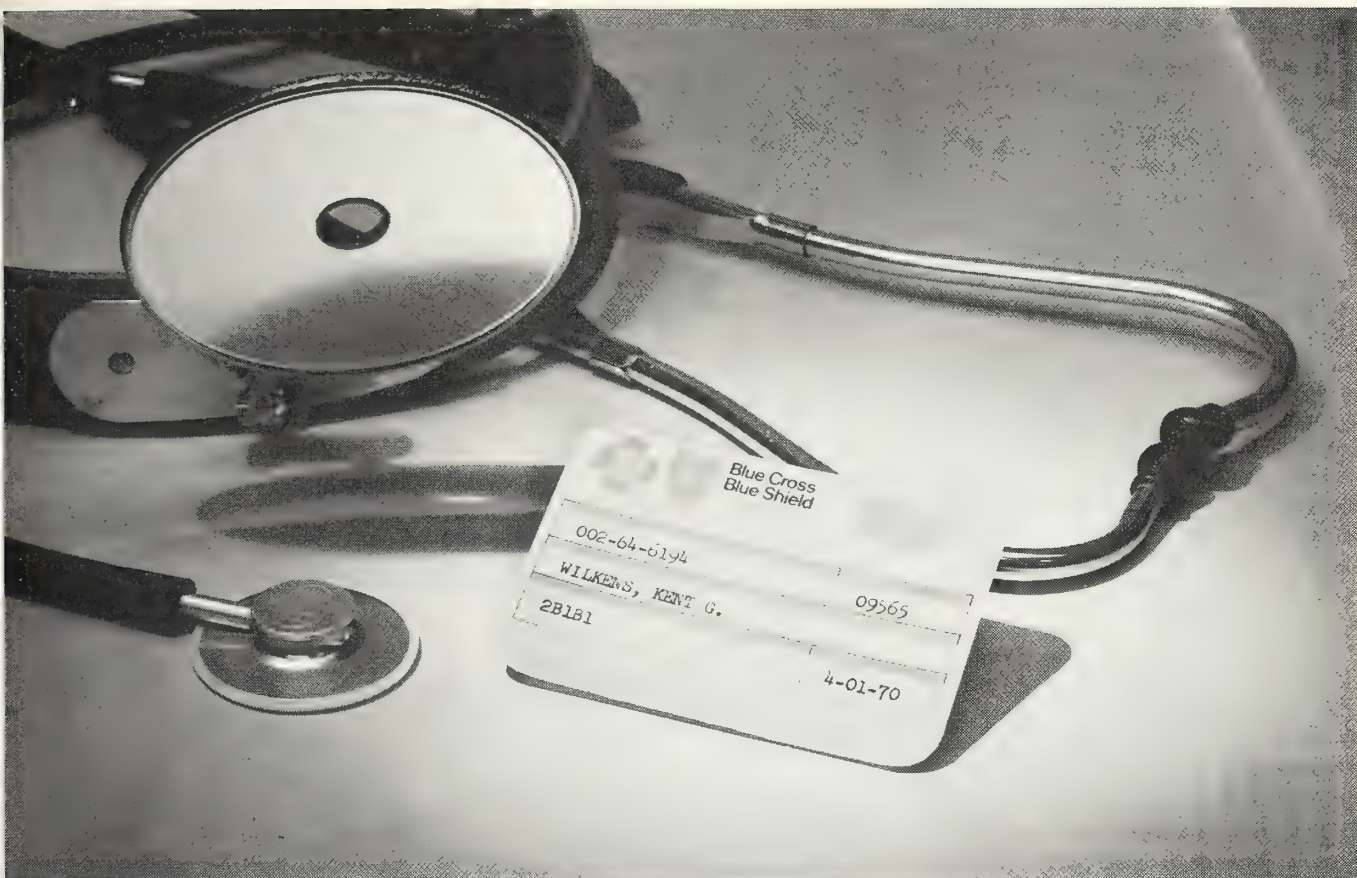
CONTINUED ON PAGE 1034

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



Roche Products Inc
Manati, Puerto Rico 00701

Take advantage of a great association!



Get these special benefits — available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage — and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association — entitling you to special group rates for these benefits:

- One full year in-hospital care
- 100% semi-private room and hospital extras
- Allowances for surgery, anesthesia, obstetrics, medical visits, diagnostic and radiation therapy
- \$250,000 Major Medical Benefits

That's not all. You also benefit from the immediate recognition and automatic acceptance of the Blue Cross and Blue Shield membership card. The special rates available through the Indiana State Medical Association membership make this coverage your best investment in personal protection. You can get it — now.

Call or write: Mrs. Kathryn Eads,
Professional Accounts, Blue Cross and Blue
Shield of Indiana, 120 W. Market Street,
Indianapolis, Indiana 46204. Telephone: (317)
263-4925.

120 West Market St.
Indianapolis, Ind. 46204

* Reg. Mark Blue Cross Assn
** Reg. Serv. Mark. Nat'l Assn
of Blue Shield Plans



**Blue Cross
Blue Shield**
of Indiana

Contents

SCIENTIFIC ARTICLES

- 1063 Practical Management of Diabetes for Family Practitioners—**
Charles M. Clark, Jr., M.D.
(Eleventh Continuing Medical Education Article)
- 1068 Immunoblastic Lymphadenopathy—***Swei H. Tsung, M.D.*
- 1072 Infantile Rickets—***Harold E. Stadler, M.D.*
- 1074 Nicotine Addiction: Treatment with Medical Hypnosis**
(Part I)—*Hanus J. Grosz, M.D.*
- 1076 Hypertension IX—Pheochromocytoma: Diagnosis**
and Management—*J. Howard Pratt, M.D.*
- 1079 Psychotherapy: What Is It?—***David F. Wehlage, M.D.*

EDITORIALS

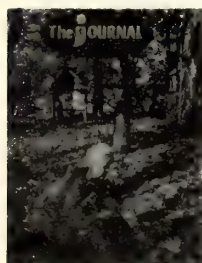
- 1030 Indianapolis Museum of Art**
- 1030 Texas, California Medicaid Programs**
- 1030 The High Cost of Medical Care**
- 1035 Editorial Notes**

SPECIAL FEATURES

- 1036 ISMA's New President: Dr. James A. Harshman**
- 1038 The Washington Monument Ploy**
- 1046 Physician Fees: Overtaken by Inflation**
- 1048 Why Does the Earth Turn?**
- 1053 ISMA Target: Insurance Coverage**
- 1054 Opposition Didn't Stop Her: Dr. Elizabeth Sowa**
- 1055 Surgeon Likes Immediate Results: Dr. Shirley Price**
- 1058 The Impaired Physician: A Treatable Problem**

DEPARTMENTS, MISCELLANEOUS

- | | |
|----------------------------------|------------------------------------|
| 1024 What's New? | 1086 Statement of Ownership |
| 1028 Medical Museum Notes | 1087 Book Reviews |
| 1043 Tax Tips | 1089 News Notes |
| 1056 Auxiliary Report | 1096 Obituaries |
| 1084 Future File | 1096 Letters |



ABOUT THE COVER

For some of us autumn leaves are a nuisance—a chore. But for others, and our cover girl is no exception, falling leaves simply represent another of Mother Nature's joys. PHOTO COURTESY OF INDIANA DEPARTMENT OF COMMERCE

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue.

Representative for national advertising is the State Medical Journal Advertising Bureau, 711 South Blvd., Oak Park, Ill. 60302.

Annual subscription rates: ISMA members, \$8, included in annual membership dues; ISMA senior members, \$10; Libraries, \$12; all others, \$14. Additional postage: Canada and PUAS countries, \$2; Foreign, \$3. Subscriptions are renewable in July and January.

Entered as second class matter January 25, 1933, at the Post-office at Indianapolis, Indiana.

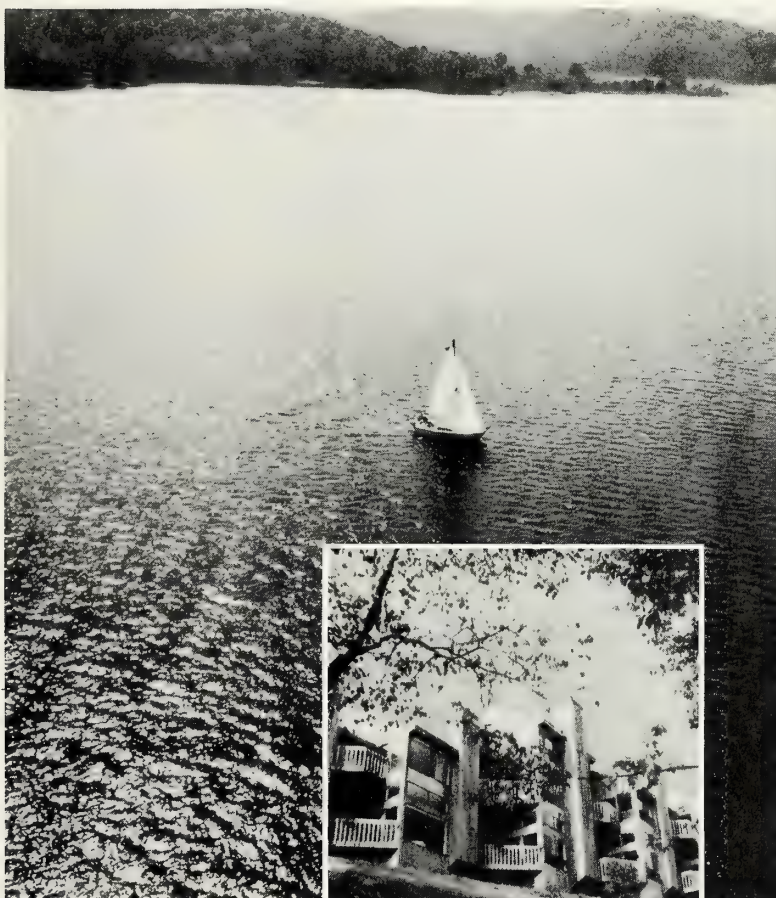
THE JOURNAL of the Indiana State Medical Association (USPS 284-440) is published monthly by the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208. Second-class postage paid at Indianapolis, Ind., and at additional mailing office. No copyright is claimed.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

Our International Standard Serial Number is ISSN 0019-6770.

Indexed in Index Medicus and Hospital Literature Index.

65 Miles from Indianapolis, there's a fabulous residential resort called The Pointe. You can call it home.



You're lucky. Living in Indiana puts you within comfortable weekending distance of a world of recreational and residential pleasure other people can only visit on special occasions.

Your special occasions can happen 52 times a year. When you can enjoy a world of beauty and recreation overlooking 22,000 acres of shimmering lake, set amid the hills and woodlands of Hoosier National Forest. It's a resort world, complete with every facility, from yacht club and marina to restaurant and lounge. Beaches, boating, fishing. Living.

It's a private world of community recreation. The Pointe's own PGA championship golf course, swimming pool, tennis courts, gourmet dining and conviviality in the clubhouse's restaurant and lounge.

And a residential world — an almost endless variety of holiday and full-time homes. Comfortable one-bedroom vacation homes to year-round family homes up to 3 bedrooms. From as little as \$29,990 to \$79,990. Four distinctive communities, each with its own variety of designs.

Discover it for yourself. Call (812) 824-7022, collect. Or drive out SR-37 South to the Harrodsburg exit and follow the signs. Models are open 10 till 7 daily. Start living a full-time vacation.



The Pointe on Lake Monroe

MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

Edward J. Goodwin, M.D., of Posey County, "discovered" in 1888 that the true value of pi is 3.2, and almost succeeded thereby in making circles and spheres bigger in Indiana than anywhere else in the world. His few years' work with circles and squares attracted more attention than did his many years in the practice of medicine.

Edward Goodwin was born near Lynchburg, Virginia some time during the 1820s (exact year uncertain). He was apprenticed by John H. Patterson, M.D., of Lynchburg from 1851 to 1854, following which he attended the series of lectures at the Philadelphia College of Medicine for the sessions of 1853-54, and for 1854-55. His M.D. degree was granted at the conclusion of the second series of lectures.

He returned to Virginia and practiced medicine in Tazewell County, not far from the borders of Kentucky and West Virginia. He remained in this area until 1867. What military service, if any, he served is unknown. His location suggests that such service, if any, would have been on the Confederate side.

In 1867 Dr. Goodwin moved to Indiana, first to Orange County, then to Gibson, and finally Posey County (in 1878) where he lived until his death in 1902. During this period the doctor's mode of transportation changed from horseback to the horse and buggy.

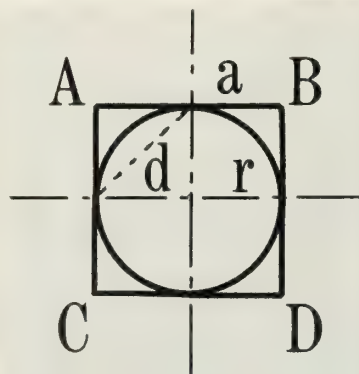
In June 1876 the business segment of Owensville, including Dr. Goodwin's office, was destroyed by fire. His wife died soon after these unfortunate events, inducing him to move on to Posey County, first to New Harmony and finally to Springfield.

In opening his new office in New Harmony, Dr. Goodwin got off on the wrong foot. He distributed an advertisement that his

New Harmony colleagues considered to be in violation of the code of medical ethics. The ill feeling precipitated by this incident led to his ultimate move to Springfield.

(I find no mention of Dr. Goodwin in the *TRANSACTIONS OF THE INDIANA MEDICAL SOCIETY* of this period, nor is he listed in Kemper's biographical volume, *MEDICAL HISTORY OF INDIANA*, which appeared in 1911, and which at least mentions the names of Indiana physicians who belonged to the Society during this period.)

As mentioned above, it was not as a physician that Dr. Goodwin is



$$\pi = 3.2$$

remembered, but rather by his interest in mathematics. In the 1880s he became obsessed with the relationship of the circle to the square. His studies led him to the conclusion that the value of pi, 3.1416 . . . , was in error, and that the true value should be 3.2. Dr. Goodwin wanted to announce this discovery to the world at the Columbian Exposition in Chicago in 1893. The space originally granted to him, however, was revoked. His concepts were then published in the *AMERICAN MATHEMATICAL MONTHLY* in 1894, his article being entitled "Quadrature of the Circle."

He next had his formulas copyrighted in the United States, Eng-

land, Germany, Belgium, France, Austria, Italy and Spain. Following this he made the unusual move of attempting to legitimize his mathematical laws by way of the Indiana State Legislature.

In 1897 "a bill for an act introducing a new mathematical truth, and offered as a contribution to education . . . by the State of Indiana" was considered by the House and by the Senate.

The bill (HB 246) passed the House unanimously Feb. 5, 1897. Five days later it passed the first reading in the Senate.

Professor C. A. Waldo, a member of Purdue University's Mathematical Department, happened to be present when the bill was presented in the House. He was amazed that the doctor's erroneous concepts were accepted so naively. He sought the appropriate contacts in the Senate and explained to them the ludicrous situation. As a result, the bill was never brought up for a second reading. HB 246 of 1897 was never defeated, but remains postponed indefinitely.

The reader who would like more detail on Dr. Goodwin and his mathematics is referred to the very interesting articles by Arthur E. Holleburg of Valparaiso (*Proc. Indiana Acad. Sci.* 84:374-379, 1974) and Will Edington (*Proc. Indiana Acad. Sci.* 45:206-210, 1935). Holleburg provides extensive research on Dr. Goodwin, and Edington provides detail of HB 246 on House and Senate action.

Peter Beckmann, in his book *A HISTORY OF PI* (1971, St. Martin's Press, New York), gives the history of the concept of pi, and gives examples, in addition to those of Dr. Goodwin, of others who became enchanted and fooled by squaring the circle. These three sources provide the information for this column.

Your Patient Saves Dollars with Generics by PUREPAC

Here's Proof!

These products and prices were taken directly
from newspaper advertising by various retail pharmacies.

QUANTITY	BRAND NAME®	PRICE	PUREPAC GENERIC	PRICE	SAVINGS
30	Polycillin (250 mg.)	\$8.70	Ampicillin (250 mg.)	\$2.40	\$6.30
100	Equanil (400 mg.) [Ⓢ]	8.09	Meprobamate (100 mg.) [Ⓢ]	1.83	6.26
100	Darvon Comp. 65 [Ⓢ]	7.83	Propoxyphene HCl Comp. 65 [Ⓢ]	4.63	3.20
100	Pavabid (150 mg.)	11.73	Papaverine HCl T.R. (100 mg.)	4.33	7.40
100	Thorazine (50 mg.)	6.03	Chlorpromazine HCl (50 mg.)	3.23	2.80
100	Librium (10 mg.) [Ⓢ]	7.11	Chlordiazepoxide HCl (10 mg.) [Ⓢ]	4.89	2.22

The savings add up! So, when you prescribe generics, specify Purepac,
the largest generic manufacturer in America.

Brand names are registered trademarks of
Bristol Labs., Wyeth Labs., Eli Lilly & Co.,
Marion Labs., Smith Kline & French Labs.,
Roche Labs. respectively.



PUREPAC

Elizabeth, NJ 07207

AMERICA'S LEADING NATIONAL BRAND OF GENERICS

EDITORIALS

Indy Museum of Art Seeks Funds

The Indianapolis Museum of Art is now conducting its annual campaign for its Operating Fund. Because the benefits of the myriad activities of the museum extend to all classes of citizens and are available to those in a large area of central Indiana, the campaign will be active over considerable distances and will occupy several months.

The museum is constantly expanding its various cultural programs. A multitude of exhibitions, classes, lectures, films and concerts are scheduled at increasing frequencies and are open either free of charge or at modest cost.

A statewide team of doctors and more than 1,500 business, industry, professional and civic-minded volunteers are working together in soliciting support for this magnificent cultural institution in which we all may take pride.

An appeal is hereby entered for a hospitable reception for the present requisition of our interest, friendship and monetary support.

Texas, California Medicaid Programs Compared

The Medicaid drug programs in Texas and in California are conducted with controls that differ significantly. A recent survey of the effectiveness of the two programs from 1973 to 1976 has been conducted by Eli Lilly and Company.

The California method was to limit choice of drugs and to control ingredient prices. Medi-Cal ingredient prices of products covered by the scheme rose 28.6% as contrasted to the single-source drugs (not covered), which rose only 15.6%.

The overall ingredient price for Medi-Cal was 20.2% compared with the Texas experience with a

unit price growth of only 9.9%.

The Texas controls consisted of management of utilization and limitation of fraud without limitation of choice or price of drugs.

The fact that Texas achieved excellent results from utilization control is demonstrated by the finding that 46% of the Medi-Cal drug increase was assignable to utilization variables.

There was no recipient discontent in Texas despite controls that were more patient-oriented. A Harris opinion poll shows that there is more public support for the total Medicaid program in Texas, and the recipients and taxpayers of both states are equally pleased with their respective Medicaid drug programs.

The High Cost of Medical Care

When you listen to those who want a national health service, you find that one of their reasons is that they wish to control costs and lower the bill. They argue that government medicine would not be so expensive and at the same time would be of good quality and almost certainly of better quality than we enjoy now.

Harry Nelson, medical writer for the LOS ANGELES TIMES, was in Europe this summer to observe various types of government medicine. His observations are interesting.

Nelson's findings: American and European medical practices share the same problem—both are too expensive. "No longer can any nation afford to give its health providers a blank check." It is evident to Nelson that both the private system and the government system will be obliged, in the future, to establish priorities for health care.

It has been said before: "There is not enough money in the world to provide all the modern, up to the last notch, luxurious medical service that the American

CONTINUED ON PAGE 1035

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 3935 N. Meridian Street, Indianapolis 46208.

Consulting Editors: A. W. Cavins, M.D., R.R. 25, Box 172, Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1, Box 202, Gaston 47342; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne 46802; I. W. Wilkens, M.D., 4820 E. Pleasant Run Pkwy., N. Dr., Indianapolis 46201; W. D. Snively, Jr., M.D., R.R. 1, Box 227, Evansville 47712; Charles A. Bonsett, M.D., 6133 E. 54th Place, Indianapolis 46226.

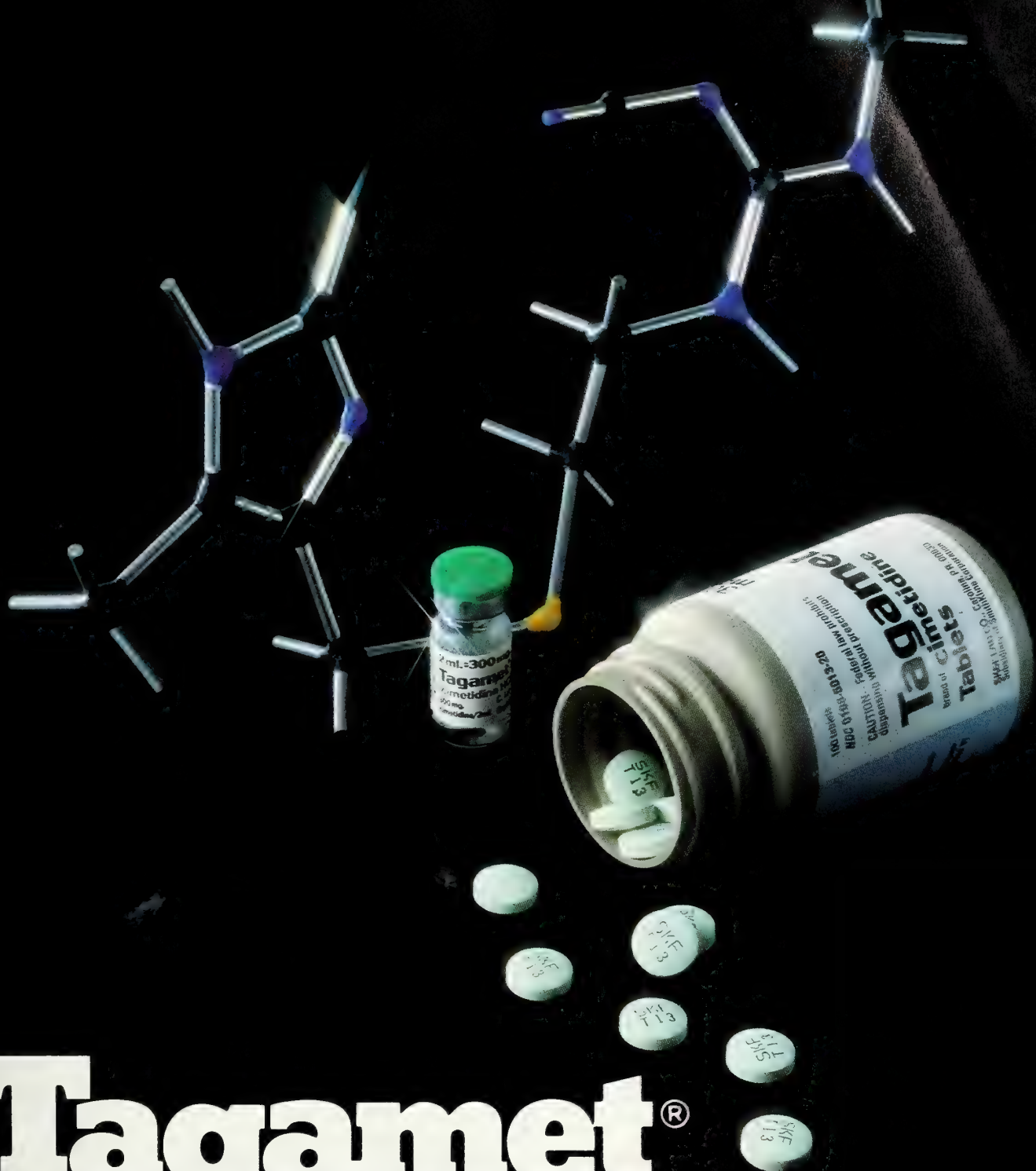
Editorial Board:

	Term Expires
Steven C. Beering, M.D., Indianapolis	Dec. 31, 1978
Paul S. Rhoads, M.D., Richmond	Dec. 31, 1978
Elton Heaton, M.D., Madison	Dec. 31, 1979
Rodney A. Mannion, M.D., La Porte	Dec. 31, 1979
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1980
Wei-Ping Loh, M.D., Gary	Dec. 31, 1980

Business Manager: Donald F. Foy

3935 N. Meridian, Indianapolis, Ind. 46208

Managing Editor: Martin T. Badger



Tagamet®

brand of

cimetidine

How Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).
Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
a SmithKline company

**When painful spasm
is the presenting
symptom...**



. in functional G.I. disorders*

Bentyl[®]

(dicyclomine hydrochloride USP)

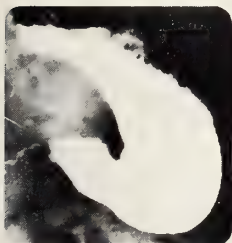
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

“The correlation of spasm relief and drug given was excellent.”

*This drug has been classified “probably” effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl[®]

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste, headache, nervousness, drowsiness; weakness, dizziness, insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. **Adults:** 1 tablet three or four times daily. **Bentyl Injection:** **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine* (bethanechol chloride USP) should be used.

Product Information as of October, 1976

WHAT'S NEW?

CONTINUED FROM PAGE 1024

Petronics of Lisse, the Netherlands, is marketing a new device which turns on lights, TV sets, and opens doors for patients with restricted motor function. The tradename is "Petromatic." It may be programmed to control operation of up to nine devices. The patient needs to have only one controlled motor function to operate the equipment.

* * *

Hewlett Packard announces a new fetal telemetry system that enables expectant mothers to walk about the hospital while the heart rate of their unborn babies is continuously monitored. Also newly announced is their new neonatal monitor-cardiorespirograph, which simultaneously records heart rate and respiration waveform to show length of apneas, changes in breathing pattern and the effects of these changes on the heart rate.

* * *

Corning Glass Works has an 18 x 24 inch wall chart that indicates by a matrix of symbols the readings to be expected from 12 thyroid diagnostic test procedures as related to hyperthyroid, hypothyroid, euthyroid or other goiter conditions. The chart may be obtained, free of charge, by addressing Corning at Medfield, Mass., 02052.

* * *

Gulf+Western has a new electronic sphygmomanometer. Designated as the S/D-600[®], it will produce reliable results in one minute for screening purposes or while doing large numbers of routine measurements. It does not require a stethoscope. An electronic sensor, mounted on the cuff, detects the Korotkoff sounds and the blood pressure is presented in direct reading digital form.

* * *

Pneumovax, Merck Sharp & Dohme's vaccine against pneumococcal pneumonia, is now available in a new package containing five single-dose vials. It will continue to be available in a 5-dose vial.

* * *

Searle Radiographics announces the Gamma/Cor Cardiac Probe, an advanced nuclear instrument which affords rapid readings of heart function and quantitative measurements of the heart's effectiveness in pumping blood. The data are recorded on a strip-chart along with the cardiogram. The device may be wheeled to the bedside. It does not involve placing a catheter in the heart.

* * *

Stuart Pharmaceuticals is introducing ALternaGEL[™], a new high-potency aluminum hydroxide antacid of special value to patients for whom magnesium-containing antacids are undesirable. The new formulation has a high acid neutralizing capacity, good flavor and a low sodium content.

* * *

Merrell

MERRELL NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215 U.S.A.

JOURNAL of the Indiana State Medical Association

EDITORIALS

CONTINUED FROM PAGE 1030

people will utilize if it is provided without limitation.”

Mr. Nelson has come to the conclusion that “people cannot continue to place indiscriminant demands on their health systems without exceeding the cost they are willing to bear. Choices must be made.”

Interestingly enough he finds that the explanations for the cost spiral are the same for all systems:

- Rapid development of new medical and surgical procedures;
- Increasingly expensive technology;
- A giant jump in the number of employees per patient;
- A rising population of elderly; and
- A rising public expectation of what medicine can accomplish.

It has been apparent for some time that there must be a system devised for fitting the amount of medical care into the price limitations that people are willing to pay. This will not be easy. So far, with the exception of politicians and labor unions, the American public, by and large, has shown a willingness, although a little begrudgingly, to seek the best medical care, no matter what the cost. Public polls indicate that almost everyone is satisfied with the quality and quantity of care received. The majority, however, complain about the cost, after the fact, without realizing that the control of cost lies within themselves.

The biggest problem medicine faces in the United States, and elsewhere, is how to fix priorities for medical care in such a way as to provide reasonably adequate care and still remain within a reasonable financial budget. This is such a large dilemma—we should have been working on it years ago.

Government medicine is not the answer. Overseas services have the same problem we do and in some cases in a worse form.

National health service will not lower the cost, it will raise it enormously.

National health service will not improve the quality of medical service; in fact, it will not preserve the quality we have now—the best in the world. NHS will depress the quality.

The immediate challenge for the medical profession and all other Americans is to set the proper priorities. The “all other Americans” are the ones on whom this challenge falls the heaviest. However, members of the medical profession must be the leaders and activators.

Editorial Notes . . .

When one hears that “drug prices are excessive” it is well indicated to answer that drug prices rose by only 22% between 1967 and 1977. At the same time the cost of living rose by 82%. Modern drugs are not only a bargain in price but they also are more effective.

HEW Secretary Califano is fond of referring to the cost of health care as increasing at the rate of \$1 million per hour. SURVEY OF CURRENT BUSINESS replies that the cost of federal government is increasing at the rate of \$5 million per hour. The National Association of Retail Druggists Newsletter quoted the above comparison and also reported that a recent Harris poll found that almost two-thirds of the Americans polled feel that “the government should have a greater involvement in the country’s medical and health care system.” But a 60-30 majority believe that “no matter how good the social program, if it is run by the government, it will always get messed up.”

Senator Edward M. Kennedy is quoted in ACTION IN PHARMACY to the effect that drugs may be used for any purpose, in any dosage or in any combination that the individual practitioner wishes. “The current system allows individual doctors to substitute their judgment for that of the Food and Drug Administration,” he says. James J. Kilpatrick (columnist) says, “Some of us in the hall heard that sentence and shuddered. The judgment, experience and professional skill of the individual practitioner must be subordinated to the judgment of the bureaucracy.”

Head-related fatalities of motorcycle riders dropped 40% following the increased usage of helmets in the 1960s. After the Highway Safety Act removed the mandatory use of helmets, at least 23 states repealed laws mandating helmets and fatalities have risen sharply. Arguments that helmets interfere with the driver’s vision cannot be supported by fact. Arguments that helmets interfere with hearing are idiotic when the motorcycle noise is considered. Indiana is one of the states that cancelled the helmet law. Eighty per cent of motorcycle crash injuries are to the head. The chance of being killed is two-thirds greater without the helmet. Everyone should campaign for helmet usage, whether required by law or not. The AMA report “Head Protection for the Cyclist” is available without charge for individuals or organizations who wish to influence cyclists to ride in safety.

Studies at the M. D. Anderson Hospital and Tumor Institute indicate that careful control of the airborne bacterial population in the quarters of patients treated by anti-tumor chemicals for acute leukemia and malignant lymphoma produce a much lesser incidence of infectious complications. Usually 50 to 60% of leukemia patients treated outside the protective unit would get a major infection. Only 25% of those patients in protective environment got infections.



ISMA Welcomes Its 136th President

JAMES A. HARSHMAN, M.D.

President

Indiana State Medical Association

1978-79

Dr. James A. Harshman was inducted into the office of presidency of the Indiana State Medical Association during ceremonies at the 129th annual meeting following a busy and eventful year as president-elect.

Dr. Harshman is a native of Indiana, having been born near Dayton in Tippecanoe County. He received his B.S. degree from Purdue University and later graduated from Indiana University with the M.D. degree.

His internship and residency in pathology were served at the Indiana University Hospitals, during which time he was also Clinical Fellow of the American Cancer Society and Resident Instructor in Pathology at the Indiana University School of Medicine.

He was a Lieutenant Commander in the U.S. Navy Reserves and served on active duty for two years at the U.S. Naval Hospital, Great Lakes, Illinois.

Dr. Harshman has been pathologist at the St. Joseph Memorial Hospital and the Howard Community Hospital in Kokomo since 1962. He is certified by the American Board of Pathology

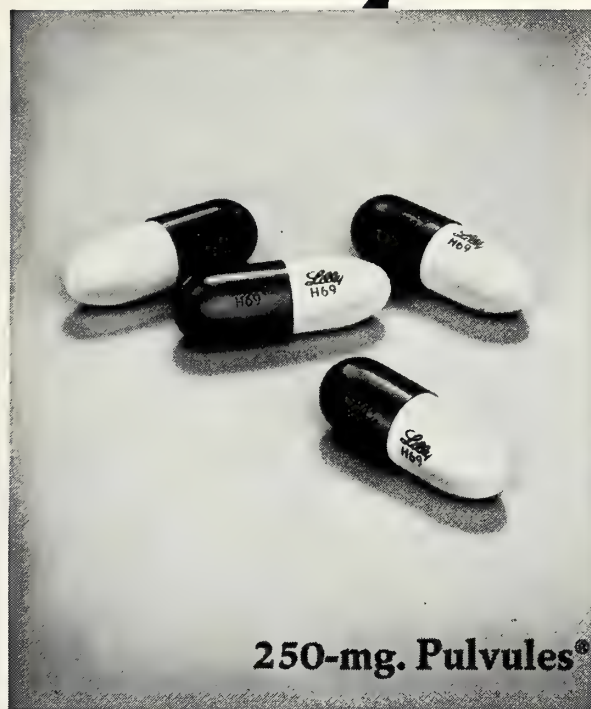
and the American Board of Nuclear Medicine.

In addition to membership in the county, state, and national medical societies, he is a Fellow of the College of American Pathologists, Fellow of the American Society of Clinical Pathologists, and is a member of the American Association of Blood Banks, the American Society of Cytology, and the Society of Nuclear Medicine.

His contributions to his many medical organizations and to his community and business organizations are legion. He has served on the Board of Trustees of ISMA and in the House of Delegates of the American Medical Association. He has been and is serving on numerous advisory councils and committees of several medical and paramedical organizations as well as serving as director for the Kokomo First Federal Savings and Loan Association.

He was married to Eva Lue Taylor, an RN from Indiana University, in 1958. They have five children, the two oldest of whom are enrolled at Purdue University and the three youngest at Northwestern High School in Howard County.

easy to take



Keflex®
cephalexin



500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

Commentary

The Washington Monument Ploy

RICHARD L. LESHER

President

U.S. Chamber of Commerce



IT IS AXIOMATIC in Washington that when a federal agency is under pressure to trim its budget, the cuts it proposes will affect the most politically popular programs under its jurisdiction. Then the agency sits back to await the inevitable outcry, secure in the knowledge that the funds will soon be restored.

The classic illustration of this process is threatening to close the Washington Monument to tourists. Consequently, the general term for the tactic is the "Washington Monument Ploy."

The wave of tax-cut legislation sweeping the country in the wake of California's Proposition 13 threatens to generate many local and state equivalents of the Washington Monument Ploy, starting with California.

I'm very firmly in favor of tax cuts and government spending limits. I've been predicting a "conservative revolution" for the last three years, and it is sweet vindication to see it arrive. But as an ardent supporter of the revolution in principle, I do not want to see it discredited in practice. And the potential for that is uncomfortably large.

Proposition 13 itself has some glaring loopholes: It puts too much emphasis on reducing the property tax and not enough on controlling all the other ingenious schemes the politicians will try to come up with to replace their lost revenue. It makes the cuts so sudden and so drastic that it invites Washington Monument Ploys. And by focusing on the local property tax alone, it fails to get at one of the worst areas of governmental waste, welfare, which in California is a responsibility of the state and national governments.

Other states are experimenting with other—and in several cases, better—kinds of spending (or taxing) limits. Tennessee, for example, has amended its constitution to limit increases in total state spending to the rate of growth of the state's economy. Another, similar, method is to limit the growth of total taxes either to increases in personal income, or to increases in total economic activity, or to the rate of inflation. Such limits leave politicians the freedom to move funds from one budget category to another and allow for reasonable growth of government to keep up with the growth of society, while still establishing a firm ceiling on total government activity.

It will be better for all concerned if it's the Tennessee-type limit that spreads, rather than the California kind. Something along Tennessee lines may even be needed at the federal level, since nothing else seems very effective in trimming the federal deficit.

For now, be on guard for the Washington Monument Ploy, and don't take the politicians' crocodile tears too seriously. So far, I've heard a lot of them wailing, "The people should leave these decisions to us," or words to that effect.

But that, of course, is precisely the problem. We *did* leave the spending decision to the politicians, and the politicians ducked that responsibility. They found it was easier to increase the budget—through borrowing, higher taxes, inflation, or all of the above—than to make the tough decisions on how to allocate a limited amount of revenue among competing interest groups.

Politicians may find that constitutional spending ceilings are actually a blessing in disguise. A firm limit gives them something to stand on when denying largess to all of these people who think they have a better right to your money than you do.

**YOU'LL GET PROMPT
PROFESSIONAL RESULTS
WHEN YOU REFER A
HEARING-IMPAIRED
PATIENT TO A**

Beltone[®]

Hearing Aid Specialist

**IN INDIANA
YOUR INDEPENDENT AUTHORIZED DEALERS ARE:**

Wayne Ankenbruck
Belton Hearing Aid Service
628 East Wayne
Ft. Wayne, Indiana 46802
(219) 422-9821

Gene Arnel
Belton Hearing Aid Center
322 W. Main
Madison, Indiana 47250
(812) 265-2365

Milton A. Brinza
Belton Hearing Aid Center
809 Merchants Bank Building
Terre Haute, Indiana 47808
(812) 232-8172

D. W. Childers
Belton Hearing Aid Center
1128 - 16th Street
Bedford, Indiana 47421
(812) 275-7498

Belton Hearing Aid Center
220 South Walnut Street
Bloomington, Indiana 47441
(812) 334-3918

Kenneth L. Hoon
Belton Hearing Aid Service
2039 East Main Street
Richmond, Indiana 47374
(317) 962-4332

Charlie P. Johnson
Belton Hearing Aid Center
1827 - 25th Street
P.O. Box 341
Columbus, Indiana 47201
(812) 372-1886

Van L. Julian
Belton Hearing Aid Service
2574 Charlestown Road
New Albany, Indiana 47150
(812) 945-0235

Earl S. McDaniel, Jr.
Belton Hearing Instruments
2801 Lincoln Avenue
Evansville, Indiana 47714
(812) 479-1437

Belton of Vincennes
Security Bank Building
20 North 3rd - Suite 338
Vincennes, Indiana 47591
(812) 882-4715

L. B. O'Connell
Belton Hearing Aid Service
1906 East Main Street
Lafayette, Indiana 47901
(317) 447-6535

Anita Reid
Belton Hearing Aid Service
1403 Brown Street
Anderson, Indiana 46016
(317) 643-3389

Belton of New Castle
1936 South Memorial
New Castle, Indiana 47362
(317) 521-2970

Belton of Muncie
1404 Granville Square
Muncie, Indiana 47362
(317) 288-8737

Belton of Kokomo
404½ Arnold Court
Kokomo, Indiana 46901
(317) 453-1944

Belton of Logansport
308 East Broadway
Logansport, Indiana 46947
(219) 753-3510

Belton of Peru
51 South Broadway
Peru, Indiana 46970
(219) 472-1410

Tom Sotos
Belton Hearing Aid Service
136 Sibley Street
Hammond, Indiana 46320
(219) 931-5272

Belton Hearing Aid Service
4581 Broadway
Gary, Indiana 46409
(219) 884-4144

Stanley Thomas
Belton Hearing Aid Service
724 W. Washington Avenue
South Bend, Indiana 46601
(219) 287-7221

Belton Hearing Aid Service
401 West Marion
Elkhart, Indiana 46514
(219) 674-5957

G. A. Van Hoose
Belton Hearing Aid Service
115 N. Pennsylvania Suite 1156
Indianapolis, Indiana 46204
(317) 632-3116

L. B. O'Connell
Belton Hearing Aid Service
1906 East Main Street
Lafayette, Indiana 47901
(317) 447-6535

Beltone

WORLD LEADER IN HEARING AIDS AND HEARING TEST INSTRUMENTS

ELECTRONICS CORPORATION

4201 West Victoria Street • Chicago, Illinois 60646

An American Company

DEAR DOCTOR,

Are you fed up with administrative/insurance hassles? Do your children go for days without having a chance to share their growing experiences with you? Have you considered a change? If so, now is the time to look into Navy Medicine. Our office is prepared to provide you and your family with the fullest information possible, and to coordinate contacts with your peers within Navy Medicine who will tell you how they see it; frankly and clearly.

Physicians with prior service, new graduates and established practitioners in many specialties are sought to assume roles in a geographically attractive array of medical centers and hospitals. You are offered the opportunity to practice with autonomy, providing the quality of care which results in a warm feeling of accomplishment. Your peers (and you) are carefully screened before being offered a commission as a U.S. Navy Officer and, as a result, have a full practice providing health care for not only young men and women, but children and retired persons as well. And, with Navy Medicine, you will have continuing, meaningful patient relationships conducive to empathetic delivery of health care resulting in the optimum of health status.

The time is right. Call me today for information. No obligation on your part is expected.

LT. BOB JONES, R.N., B.S.N.
575 North Pennsylvania, Room 646
Indianapolis, Indiana 46204
1-800-382-9404

NAVY MEDICINE.
IT'S NOT JUST A JOB!

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Products Inc.
Manati, Puerto Rico 00701



In treating certain G.I. disorders ...

Enhance your therapeutic expectations
with the triple benefits of

Adjunctive
Librax

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

Librax is unique among G.I. medications
in providing the specific antianxiety action of
LIBRIUM® (chlordiazepoxide HCl) as well as the potent
antisecretory and antispasmodic actions of
QUARZAN® (clidinium Br) for adjunctive therapy
of irritable bowel syndrome* and duodenal ulcer.*

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

In pharyngitis and tonsillitis

...prompt temporary relief
of pain even before
patients leave
your office.

CĒPASTAT

mouthwash/gargle/sore
throat lozenges

Merrell

Proven Anesthetic Effectiveness

Spraying the throat with CĒPASTAT brings soothing relief within minutes. Your patients will appreciate this relief while waiting for therapeutic measures to take hold. The well-established anesthetic effects of CĒPASTAT provide soothing temporary anesthesia to the irritated or inflamed oropharyngeal mucosa.

CĒPASTAT in your treatment room . . .

Used as a spray, CĒPASTAT is more likely to deliver the most relief to the painful area of the throat.

Suit the product to the patient . . .

The liquid is best for use at home as a spray or gargle. Lozenges are ideal for patients on the go.

A recommendation is best . . .

It costs less. Keeps the emphasis where you want it . . . on more important counter-measures — your prescription for anti-infectives, for example.

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



relief of minor
sore throat when
patients want it

stat



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article continues my discussion of the gift and estate tax sections of the Tax Reform Act of 1976 (TRA) and the proposed changes which are in the Technical Corrections Bill (TCA). Specifically, this article continues my discussion of the estate tax rates and the estate tax credits.

As the reader may remember, step one and step two of the gift tax computation are made without regard to any portion of the new unified gift tax credit which might be available under the new gift tax law. The reason why the unified credit is not used to reduce either the first or second step of the gift tax computation is because the unified gift tax credit itself is reduced by prior uses of the unified gift tax credit. Thus, to reduce the gift tax computation, in either step one or step two, by any unified gift tax credit which the donor had previously used, would, in a sense, be a double reduction of the donor's unified gift tax credit.

However, in the case of step two of the estate tax computation, the decedent's gift tax is computed after reduction by any applicable unified gift tax credit. The reason for this is because, as I discuss below, the estate tax credit itself is *not* reduced by any of the decedent's prior uses of the gift tax unified credit (and the unified estate tax credit could certainly not be reduced by prior uses of the unified estate tax credit).

It should also be noted that the inclusion of the decedent's post-1976 taxable gifts in step one of the estate tax computation may have the undesirable effect (from the decedent's viewpoint) of pushing the decedent's taxable estate into a higher estate tax bracket. However, the subtraction of the gift tax on the post-1976 gifts in step two prevents the double taxation of the post-1976 gifts.

Now, if the reader understands the new gift and estate tax computation, as discussed so far, then it will not be difficult to integrate the concept of *adjusted taxable gifts*. The only function of *adjusted taxable gifts* (as opposed to just *taxable gifts*) is to assure that—in step one of the estate tax computation—the estate tax is not based upon the same gifts *twice*. That is, because step one in

the estate tax computation is based upon the decedent's lifetime taxable gifts (since 1976) plus the decedent's taxable estate, ostensibly, the step one computation could result in the estate tax being imposed upon all of the decedent's post-1976 taxable gifts plus the decedent's taxable estate, which taxable estate itself may include some of the decedent's post-1976 gifts, for example, gifts which the decedent made within three years of the decedent's death and which are includable in the decedent's gross estate, for estate tax purposes, under section 2035.

To avoid this possible double taxable of certain gifts under step one of the estate tax computation, section 2001(b) defines the term *adjusted taxable gifts* as the taxable gifts which a decedent made (or is treated as having made due to the gift splitting provisions of section 2513) during the decedent's life (and after 1976)—*other than* gifts which are includable in the decedent's gross estate, for estate tax purposes. Thus, if the decedent made taxable gifts during the decedent's life, which gifts are includable in the decedent's gross estate (and therefore, are includable in the decedent's taxable estate), then, such taxable gifts are not includable in the taxable gifts of a decedent which are added to the taxable estate of the decedent in order to compute the result of step one of the estate tax computation.

One way of thinking of this is: if some of the decedent's taxable gifts are includable "at the top of the step one computation" (that is, in the decedent's gross estate) then such gifts are not also includable "at the bottom of the step one computation" (that is, in the decedent's taxable gifts which are added to the decedent's taxable estate).

As stated above, the most obvious example of taxable gifts which could be includable in the decedent's gross estate, for estate tax purposes, are gifts which the decedent made within three years of the decedent's death, and therefore, are includable in the decedent's gross estate under section 2035. Other examples are: gifts which are made upon the creation of interests with rights of survivorship in property with the donor and another

person, which interests are later includable in the decedent's gross estate under section 2040; and, gifts which are made by transfers of interests in trusts, which interests are later includable in the decedent's gross estate under sections 2036, 2037, or 2038. However, in these "other" examples, and many more, the precise computations which will have to be made, in computing the estate tax, will have to be prescribed by the Regulations. That is, in these latter cases, the computations are more difficult than they appear at first glance.

Another important point concerning the term *adjusted taxable gifts* is that step two of the estate tax computation does not refer to this term. That is, step two of the estate tax computation (under section 2001(b) (1)) requires the decedent to compute a tax on the decedent's post-1976 taxable gifts, without any reduction for the taxable gifts which are includable in the decedent's gross estate, for estate tax purposes, for example, due to the three-year rule of section 2035. Perhaps, the best way to understand this difference (between the step one and step two computations of the estate tax computation) is to remember that the decedent did, in fact, either: pay gift tax on these step two gifts; or, use the decedent's unified gift tax credit to eliminate the gift tax. For example, assume that a decedent had made taxable gifts within three years of the decedent's death, and that the decedent paid gift tax on these gifts, because the decedent's unified gift tax credit did not eliminate all of the gift tax. In such a case, step one of the estate tax computation requires a tax to be imposed upon these gifts. That is, step one imposes a tax on these gifts because these gifts are includable in the decedent's gross estate (under section 2035), and thus, these gifts are part of the decedent's taxable estate. However, these gifts are not taxed in step one as part of the decedent's taxable gifts, because these gifts are removed from the decedent's taxable gifts when computing the decedent's adjusted taxable gifts. Therefore, because step one of the estate tax computation imposes a tentative tax on the gifts on which the decedent already paid a gift

TAX TIPS

tax, step two of the estate tax computation allows the decedent to offset the tax computed in step one (on these gifts) by the tax computed in step two (on these gifts). Obviously, this offset avoids the potential double taxation of these gifts.

Therefore, regardless whether a decedent's taxable gifts are includable in the total amount on which the step one tax is imposed because the gifts are part of the decedent's gross estate (and therefore, part of the decedent's taxable estate and not part of the decedent's adjusted taxable gifts) or because the gifts are part of the decedent's adjusted taxable gifts (and therefore, not part of the decedent's taxable estate), the gifts will have a tax imposed on the gifts in the step one estate tax computation. That is, post-1976 gifts will have the step one computation imposed upon them either because the gifts are part of the decedent's adjusted taxable gifts, or alternatively, because the gifts are part of the decedent's taxable estate.

Thus, to repeat, a decedent's post-1976 taxable gifts will be taxed in step one (one way or the other), and, if the decedent is not allowed to offset this step one tax with the tax which the decedent paid, in fact on the gifts, then the decedent will pay tax on the gifts twice—once during life and once at death.

If a decedent did not pay any gift tax on the gifts (because the gift tax exclusions and gift tax deductions eliminated any taxable gifts, or, because the decedent offset the potential gift tax by the unified gift tax credit), then, because step two of the estate tax computation (which computes the actual gift tax which the decedent would have paid on the gifts, after taking into account any use of the decedent's unified gift tax credit) would result in a zero tax for step two, the net effect of this situation would be that the decedent's post-1976 taxable gifts would not have been taxed for gift tax purposes, but they will be taxed for estate tax purposes, and then, the estate tax may be reduced by the decedent's unified estate tax credit.

Now, if the reader understands the meaning of the term *adjusted taxable gifts*, and if the reader is confident of the reader's understanding of the two-step estate tax computation, then the reader may be disappointed when reading the following comments. That is, it may be more than three years after 1976 before the reader adds (in step one of the estate tax computation) any adjusted taxable gifts to a decedent's taxable estate. The reason why decedents who die in 1977, 1978, or 1979 will have no adjusted taxable gifts is because adjusted

taxable gifts are all gifts which an individual gives after 1976 *minus* any gifts which are includable in the individual's gross estate, for estate tax purposes. And, all of the gifts which a decedent makes during 1977, 1978, and 1979 will be includable in the decedent's gross estate, for estate tax purposes, under the three year rule of section 2035 if the decedent dies within the years of 1977, 1978, or 1979. Thus, in such a case, the adjusted taxable gifts for such decedents will equal zero. As a consequence, the new estate tax computation (insofar as *step one* is concerned) will be virtually the same as the pre-TRA computation, namely, the application of the new estate tax rates to the decedent's taxable estate (with no addition, to the taxable estate, of the decedent's adjusted taxable gifts). The one possible exception to this is dependent upon the Internal Revenue Service's interpretation of an election during 1977, 1978, or 1979 (by an individual who acquired real estate and put the title to the real estate with survivorship rights with the individual's spouse prior to 1977) to have the gift subjected to the new gift tax, by electing the treatment under section 2515 (as that section is proposed to be amended by the TCA). The question is: will such an election bring the gift within the scope of new section 2035 even though the formal creation of the survivorship interest was prior to 1977?

In any event, as discussed above, step two of the new estate tax computation will compute a tax on all of a decedent's post 1976 taxable gifts, taking into account the decedent's unified gift tax credit, because such a decedent may have, in fact, paid a gift tax on these post-1976 gifts.

There is one further point which I wish to make concerning the concept of *adjusted taxable gifts*. If a donor makes a post-1976 gift (to a third person) and the donor's spouse consents to split the gift for gift tax purposes under section 2513, and then, such consenting spouse dies within three years after the gift, such consenting spouse is not required to include the gift in such consenting spouse's gross estate, for estate tax purposes, under section 2035. On the other hand, if the donor-spouse dies within three years of the gift, then the donor-spouse must include the gift in the donor's gross estate, for estate tax purposes, under section 2035, and, under the current wording of section 2001, the donor is entitled to a credit against the donor's estate tax for the amount of any gift tax which is payable with respect to a gift which is treated as being made by the consenting spouse due to the section 2513 election. However, the TCA proposes an amendment to section 2001

which would prevent the donor from benefiting (when computing the donor's estate tax) from any gift tax which the consenting spouse paid on gifts of the donor which were split between the spouses and which are includable in the donor's gross estate, for estate tax purposes, under section 2035.

Further, the TCA proposes an amendment, to section 2001, which would allow the consenting spouse to exclude such gifts of the donor (which were split and later includable in the donor's gross estate, for estate tax purposes, under section 2035) from the computation of the consenting spouse's adjusted taxable gifts, for estate tax purposes, regardless whether the consenting spouse dies within or after the three-year period of section 2035. Thus, while the consenting spouse may pay gift tax (or absorb the consenting spouse's unified gift tax credit) during the consenting spouse's spouse's life, on the donor's gifts which are treated as being made by the consenting spouse but which are includable in the donor's gross estate under section 2035, the effect of such payment (or absorption of the unified gift tax credit) will be eliminated at the death of the consenting spouse, if the current TCA proposal is enacted. Unfortunately, this reversal will not come about until the death of the consenting spouse, and thus, the consenting spouse will "lose interest" on any money which the consenting spouse used in order to pay gift tax which was directly (or indirectly) imposed on these gifts of the donor.

Note again, in this two-step estate tax computation, the decedent does not involve taxable gifts from years *prior* to 1977. I repeat this, because I think that one of the most difficult aspects of learning the new gift and estate tax law is remembering when to involve transactions of years prior to 1977 and remembering when not to involve transactions in such years. Thus, I might pause in order to restate three points which I have already made. First, in the case of the *gift tax marital deduction*, the donor only considers gifts which are made after 1976. The same is true for the purpose of computing both steps of the new two-step *estate tax computation*. However, in the case of application of the new *gift tax rates* (in both step one and step two), the donor must consider taxable gifts which are made prior to 1977 and those which are made after 1976.

To the physician whose practice needs a new perspective.

Look into Air Force Aerospace Medicine.

As an Air Force Flight Surgeon, you will have a truly general practice on the ground, while in the air you will fly with and observe air crew members — adding a new perspective to your medical career. The Air Force gives you the respect of your profession and the prestige of an Air Force officer. In addition to the numerous benefits of an Air Force career, you will also have the opportunity to compete with other

physicians for an outstanding education program. It's the way to pull your entire life into perspective — time for your family, time for yourself, and time to advance in your profession.

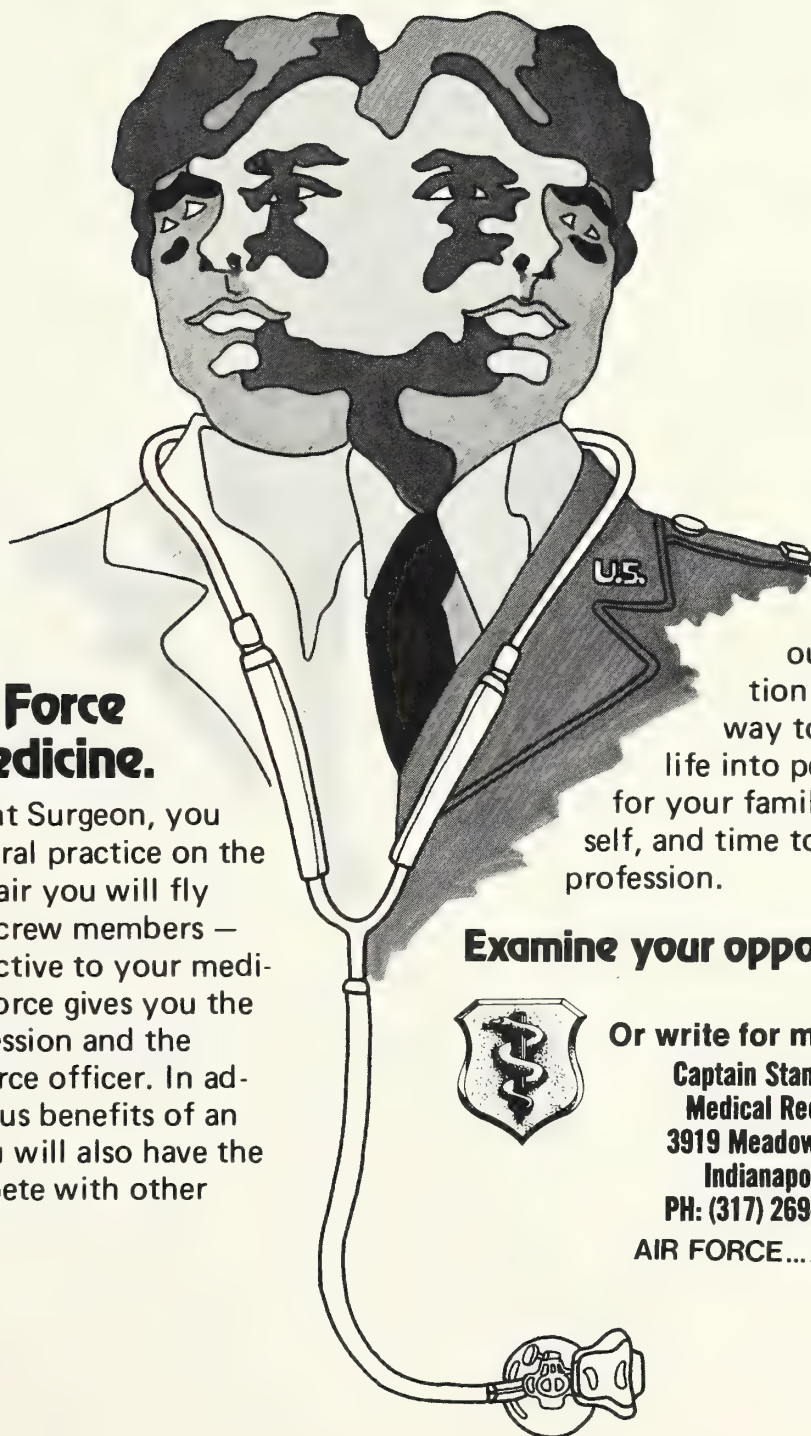
Examine your opportunities now



Or write for more information.

Captain Stanley M. Herndon
Medical Recruiting Office
3919 Meadows Drive, Suite 1
Indianapolis, IN 46205
PH: (317) 269-6624 (COLLECT)

AIR FORCE... A Great Way of Life



PHYSICIAN FEES: Overtaken by Inflation

MARTIN T. BADGER
Managing Editor

THE FINDINGS OF A HEALTH ECONOMIST will burst some balloons by showing that one of the major economic policy-making groups of the Federal Government, the President's Council on Wage and Price Stability, has demonstrated "an alarming inability to distinguish between the economic facts and the economic fallacies about physicians' fees."

The words are those of Peter H. Aranson, research professor for the Law and Economics Center, University of Miami School of Law. His comments appear in the preface of a just-published critique of the Council's 1978 staff report, "A Study of Physicians' Fees." The critique is authored by Dr. Keith B. Leffler, assistant professor of economics at the University of Washington.

Since 1970 physicians' earnings have not kept pace with the increase in the cost of living . . .

Professor Aranson declares, "The real story behind the Council's report may well be that the extension of such programs (as Medicare and Medicaid) into a full-blown national health insurance program can only lead to substantial increases in the cost of medical care, with no imaginable improvements in its quality or availability."

In his critique, Dr. Leffler flatly concludes, "The serious allegations of the Council's report are unsupported by logical analysis or by empirical fact." He says the "Medicare and Medicaid programs are the principal culprits responsible for any remaining inflation of physicians' fees."

The Council's report covers many issues, examining the level of physicians' fees over time as well as geographical variations of these fees at any given time. Moreover, it tries to pinpoint the cause of continual, substantial and persistent increases in physicians' fees.

Are physicians' earnings excessive?

Dr. Leffler, a Ph.D. who specializes in applied price theory and industrial organization, says no. In fact, he says, since 1965 physicians' earnings have grown at a rate slower than the growth in earnings of college graduates, and since 1970 physicians' earnings have not kept pace with the increase in the cost of living!

Leffler says that a detailed analysis fails to support the earnings conjectures that the government report offers.

The Council's report features tables of median earnings for office-based, non-salaried physicians, but the figures used to compare physicians' income with various alternative occupational earnings were the median earnings of *all* MDs, regardless of their specialty. This meant that the single median combined general practitioners with five years of post collegiate training, pediatricians with six to seven years of training, and surgeons with seven to eight years of training.

"As any reasonable model of investment in occupational skills would predict," Leffler notes, "the economic returns from various specialties are quite responsive to the required training. General practitioners, for example, have the lowest earnings while surgeons are among the highest paid."

From 1949 to 1975 the percentage of general practitioners fell from 63.5 to 17.2 percent, while the percentage of physicians who are specialists rose from 36.5 to 82.8 percent. Hence, Leffler says, the earnings of the "average" physician have increased—but this simply reflects the change in the percentage of general practitioners and specialists.

Leffler says that from 1955 to 1975 "college graduates' earnings increased at an annual rate of 4.9 percent while general practitioners' earnings rose at a rate of 5.0 percent."

There is no evidence, according to Dr. Leffler, to support what the Council's report terms the "stylized fact" that the American Medical Association (AMA) is directly or indirectly responsible for the alleged "excessive" earnings of physicians. The government hypothesis that the AMA controls medical school class size, the number of medical schools, and physician licensure simply does not withstand close scrutiny, Leffler says. "While some people, such as President Carter, argue that the AMA will seek to increase its members' income, the lack of success of that organization calls into question its true ability to control the output of medical schools."

Allegedly, the AMA restricts entry into the medical profession through its role in certifying and inspecting medical schools. Most states, Dr. Leffler explains, delegate their approval

process to the AMA's Liaison Committee of Medical Education, established in 1942. The committee consists of representatives from the AMA (six), the Association of American Medical Colleges (six), the public (two), and the federal government (one). The Liaison Committee's criteria for accrediting medical schools are publicly available and infrequently changed.

Rather than attributing any increase in post-1965 earnings to "organized medicine" itself, Leffler blames the problem on Medicare and Medicaid. At the time these programs were implemented physicians were in relatively short supply. And since it requires five to eight years to train a physician, and presumably nearly as long to plan and expand medical school capacity, it is not surprising, Leffler says, that physicians' earnings are still considered excessive.

"These excessive returns, which followed the enactment of Medicare, however, may be on the decline . . . Since 1970 physicians have not kept pace with inflation. General practitioners' earnings in 1975 are only \$31,300 in real 1970 dollars. This amount represents a decline in real earnings of 8 percent from 1970 to 1975."

Because a large increase in the number of physicians is expected in the next decade, Leffler says that earnings will decline and fees charged by physicians will peak out. "Classical economic demand and supply theory predicts a resulting fall in earnings and a tempering or reversal of fee inflation," he says.

Again citing the inaccuracy of the Council's report, Dr. Leffler says the government is wrong in its allegation that physicians are immune to the economic forces of supply and demand because they can set their own "target income" by increasing their fees and by unnecessarily expanding the extent of their patient services. The government's hypothesis—"target income" represents the heart of the report—"is based on the most naive assumptions about consumer and physician decision-making," Leffler says.

For example, he cites this statement from the report: "Fee levels are negatively related to demand for physicians' services—the greater the demand, the lower the fee; the lower the demand, the higher the fee."

"This supposed description of a market boggles the mind and must be a price controller's dream," Leffler asserts. "Simply expand the demand and lower physicians' fees! Indeed, the entire experience of fee inflation following Medicare is quite incomprehensible under the target income scenario."

The government's target income hypothesis,

he says, "requires one to assume that physicians have an exogenously determined 'desired' income level. To achieve the target income, physicians can simply raise fees for each service they render, or they can 'influence' demand itself by inducing patients to undergo unnecessary surgery, diagnostic procedures, or followup visits.

" . . . Yet, the report provides no explanation for a physician's selection of a target income . . . The report summarizes a study sponsored by DHEW, which finds that physicians' incomes are positively related to relative physician supply. Not only does increased supply increase physicians' fees but also physicians' incomes! One wonders, then, why the AMA fails to wage a vigorous campaign sponsoring the expanded supply of physicians."

"The government's hypothesis . . . is based on the most naive assumptions about consumer and physician decision-making . . ."

Leffler says the target income hypothesis also cannot explain why physicians in different specialties earn different incomes and why board-certified physicians earn more than those not board-certified. He chides, "Does this mean that board-certified physicians have higher target incomes? Nonsense!"

Physicians locate in areas offering the best earnings and/or specialization opportunities—areas where there are patients. Responding to greater Medicare-induced demand—i.e., normal supply and demand—explains why areas with the greatest number of physicians per capita have relatively higher fees, Leffler says.

Dr. Leffler says the results of this study "strongly suggest that physicians do not have substantial long run control over their incomes, the demands for their services, or their fees. The target income hypothesis is thus suspect on both theoretical and empirical grounds. Classical economic theory, by contrast, provides a useful description of the market for physicians' services."

He says the Council's report questions "whether a free market in supplying physicians' services will result in a socially desired efficient outcome." By responding negatively to such questions, "the report represents a subtle attack on the very principles justifying a private market economy."

Dr. Leffler concludes that "the market for physicians' services appears to be adjusting to recent increases in the supply of physicians, just as traditional economic analysis would predict."

Commentary

Why Does the Earth Turn?

RICHARD J. NOVEROSKE, M.D.
Evansville

The other day I gave a ride to a man whose pickup tires had been slashed. "Why would anyone do that?" I asked absently.

"Why does the world spin?" he answered with a question.

"Yes, why does the earth turn?" I asked myself and went on driving.

Later in the day, while driving to another hospital, it hit me. The earth spins because it's a huge electric motor. (An electric motor is a rotor with its internal magnetic field surrounded by an external magnetic field. The two magnetic fields react on one another in rhythm to produce an electromagnetic force on the rotor that turns it.)

Of course. The earth has a magnetic core with north and south magnetic poles a little off from the axis on which it rotates 360° every 24 hours, and there is a strong field of particulate radiation around the earth—the Van Allen Belt.

The Van Allen Belt is a belt of intense ionizing radiation that surrounds the earth and has concentrations of electrons and protons trapped by the earth's magnetic field. This belt is shaped and is continuously being reshaped by the solar wind as the earth moves around the sun. The Van Allen Belt extends toward the sun for about 80 megameters, but it trails off in a tail for some 5,600 megameters on the side of the earth away from the sun. It's shaped like the fuselage of an airplane.

If it is accepted that these huge layers of radiation particles from the solar wind are trapped by the earth's magnetic field, then since there is an equal and opposite reaction for every action, the Van Allen Belt also acts on the earth's magnetic field.

If there were no rhythm to this action, the effect would be to lock the rotor, to brake the earth's rotation on its axis by locking the magnetic fields. But this has not happened; the earth continues to rotate.

There must be a rhythm or periodic shift in the Van Allen Belt that produces a shifting electromotive force on the earth's magnetic field; thus, instead of braking the earth's rotation to a halt, it pulls on the earth's magnetic field and turns the earth; it is a motor.

The ultimate source of the turning power is the sun.

I am deducing this because of two general prin-

ciples: For every action there is an equal and opposite reaction—the earth's stationary magnetic field can't act on the Van Allen Belt and trap ions, without being in turn acted upon; and motor theory tells us that there has to be a shifting magnetic field to produce the electromotive force that turns the rotor—the earth in this instance. If the magnetic field doesn't shift, the rotor is locked, but it isn't, for the earth turns. So the magnetic field must shift; there must be shifting electromagnetism in the Van Allen Belt reacting on the earth's stationary magnetic field.

How the magnetic field of the Van Allen Belt shifts, I don't know. I leave the determination of the mechanism for the shift to a better mind.

Why hasn't the idea of the earth turning because it is a huge electric motor been thought of and popularized before? Probably because it turns so slowly relative to the speed of most electric motors we think of. We are used to single pole A.C. electric motors turning at 3,600 revolutions per minute and many D.C. motors turning even faster. So a motor that takes 24 hours to make one turn may not seem like a motor at all.

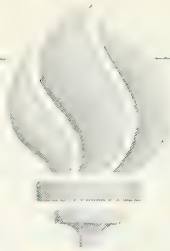
But the speed of the rotation of a motor depends on a number of factors. And when we consider the huge torque necessary to turn a mass as big as the earth, we can understand that speed must be sacrificed to get enough torque; 24 hours for one revolution on its axis doesn't seem too bad when one considers the size of the rotor.

To be sure, the other planets in our solar system and the sun itself rotate on their axes, and not all of the planets have strong magnetic fields nor Van Allen Belts, to the best of our present knowledge. Perhaps the rotation of other planets, the earth, and the sun is partially due to a gyroscope effect.

But if we concern ourselves with the facts at hand about the earth, much of the rotation appears to be due to an electric motor effect.

The person who figures out the mechanism in the Van Allen Belt that induces the shifting electromotive force on the earth's stationary magnetic field will do a great service, deserve a fine prize, and probably lead the way to more knowledge. It's a challenge worthy of a prepared person who is willing to work.

I'm not prepared for it.



ROCKWOOD

INSURANCE COMPANY OF INDIANA

Professional Liability Insurance Specialists

Physicians, Surgeons, Dentists

Hospital Professional Liability

Represented by:

Health Care Provider Insurance Agency, Incorporated

INDIANAPOLIS . . . Hadley-Mahoney Co., 3640 N. Washington Blvd. 46205
(317) 924-5331

MICHIGAN CITY . . Lindenmeyer Insurance Associates, Inc.
801 East Eleventh Street 46360
P.O. Drawer C
(219) 879-7301

SEYMOUR Wenco, Inc., Room 20, Vehslage Building
P.O. Box 518 47274
(812) 522-2931

SOUTH BEND . . . Hepler-Smith Insurance, Inc.
511 West Colfax Avenue
P.O. Box 1875 46634
(219) 232-4889 (Toll Free 1-800-552-2910)



Forget Everything you ever knew about borrowing Money

Introducing a new loan: THE PROFESSIONAL

so unique that we have over \$4,000,000.00 in personal loans made to Physicians and Dentists.

Unique Features...

• PAY ANY AMOUNT ANY DAY OF THE MONTH.

In good times, pay more. During slow periods, pay the minimum.

• WE MAKE HOUSE CALLS.

A collect call is all that's necessary to begin processing your loan. We will come to your home, office or hospital to close your loan at your convenience.

This confidential loan is made for any good purpose . . . long term or short . . . \$10,000 to \$50,000. An interest-bearing loan, it can be repaid in varying amounts and on any day. You pay only for the time you use the money. Call today.

PROFESSIONAL LOAN DIVISION

Ask for Colin G. Haza
Assistant Vice President

110 East Washington Street
Indianapolis, Indiana 46204
Phone (317) 631-1311

Indianapolis

**Morris
Plan**

Tenuate®
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977

Merrell

B-3921 (1587A)

**Whether overweight is a
complicating factor...
or just uncomplicated overweight.**

Tenuate Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

Merrell



For prescribing information see opposite page.



EMPIRIN[®] COMPOUND c CODEINE

Each tablet contains: aspirin, 227 mg; phenacetin, 162 mg; and caffeine, 32 mg; plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1); #3—30 mg (gr ½); #2—15 mg (gr ¼); and #1—7.5 mg (gr ⅛). (Warning—may be habit-forming).



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Commentary

ISMA Target: Insurance Coverage

Based on recent problems concerning participating vs. non-participating contracts, the ISMA has been asked to comment on the Motors Health Insurance Contract before it is implemented. These comments appear below.

Par vs. Non-Par Contracts

The Indiana State Medical Association finds the use of participating vs. non-participating contracts totally unacceptable.

In the first place, this Association believes that the differential reimbursement feature is illegal under the Insurance Acts of the State of Indiana, and specifically the section which states, "... making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments or rates charged or made for any policy or contract of accident or health insurance or in the benefit payable thereunder, or in any of the terms or conditions of such a contract . . ."

It is this Association's opinion that such agreements are discriminatory to patients-clients because a par vs. non-par contract severely limits the choice of physicians available to patients, works a financial hardship on both patients and physicians, and limits benefits to the patients.

Very few physicians will agree to participate under a "dictatorial practice environment" and, therefore, patients will probably have to travel greater distances to seek care—at a greater cost because of added travel expense—and from a physician not of his/her own choosing. The alternative, of course, is for the patient to continue seeing the physician of his/her choice, who is familiar with his/her problem, and pay the difference not allowed by such a contract, thereby limiting the benefits available to patients.

Deductibles

The Association strongly recommends the use of deductibles to give health care users an economic incentive to shop for cost-effective health care and make them more aware of the cost.

A recent survey conducted for the Indiana Hospital Association found that 79% of the Indiana residents questioned favor deductible plans that would require a health insurance recipient to pay all bills up to a certain amount before insurance began paying benefits.

A full-pay, open-door policy into the health care delivery system is not cost effective and can only add to the present increasing cost of medical care. The reason for choosing deductibles over coinsurance is that deductibles are easier to administer and are more effective. Deductibles are paid up front, whereas coinsurance is dependent on the filing and processing of the claim.

For insured cost sharing to be effective, the out-of-pocket expense (deductible) must be high enough so that a small medical expense, which can and should be accommodated in a family budget, is not covered by insurance. At the same time, however, deductibles should not be so high that a financial barrier is imposed against obtaining needed medical care.

The cost of first dollar coverage is quite high. When this is understood, most employers who provide group coverage for their employees and families who pay the premium for their coverage will opt for the lower premium. With the risk of small budgetable medical expenses appropriately resting upon the insured, consumer cost consciousness might be achievable.

The savings resulting from the elimination of first dollar coverage could be used to provide additional benefits, such as coverage of computerized axial tomography (body scan) and voluntary second surgical opinion programs.

Out-Patient Coverage

The Association encourages expanded coverage of out-patient services as a mechanism for containing health care costs. It is generally recognized that out-patient care is less expensive than in-patient care, and therefore should be covered wherever possible. Patients need to be better educated in the use of the health care delivery system, but the structure of insurance coverage greatly determines what services will be utilized.



"I really get depressed when I examine a youngster whose eyes are damaged because of muscular dystrophy or degenerative or inherited diseases . . ."

Dr. Elizabeth Sowa

Opposition Didn't Stop Her

DR. ELIZABETH SOWA of Evansville had more hurdles to face than most women who made up their minds to become doctors. First of all she entered medical school at 25, a later age than that of most medical students, was married the same year and had her first child 13 months later.

The wife of Dr. Ronald Sowa, an orthopedic surgeon, she said, "If we had waited until we had finished training we would have been too old to raise a family."

The mother of four—Eric, 16, Curt, 15, Melissa, 11, and Karl, 10—admits that life can become a little harrowing when trying to keep up with a private practice in ophthalmology, nurturing the family and taking her turns on call in the emergency rooms of the local hospitals. She manages because "my husband is more understanding, more considerate than some would be."

Dr. Sowa said that although she always wanted to be a doctor, she got a late start because others, including her own family physician in Flint, Mich., discouraged her. Instead, she became a medical technologist at Wayne County General Hospital in Eloise, Mich., after receiving a degree in that field from Michigan State University.

It was while she was a medical technician at the University of Michigan Medical School, working on breast cancer research in the department of surgery, that she finally said to herself, "To heck with everybody," and entered Washington University School of Medicine in St. Louis.

While interning at Wayne County General Hospital, her interest was in the study of the

effects of hormones on breast cancer. Sowa said she chose ophthalmology through a process of elimination. Her preference had been pediatrics—"but that seemed a bit much, working with sick children, with a demanding family of my own."

She then became a resident in ophthalmology at the Kresge Eye Institute, Wayne State University, from 1964-67.

As an ophthalmologist, she says she can pretty well limit her practice to the things she likes most.

"For instance, I prefer strabismus surgery (straightening an eye muscle) to removing cataracts. But when I'm on emergency, I take my turns at doing all sorts of eye surgery."

Working mainly with children, she said her profession brings her pleasure because she is making people see better. "But I really get depressed when I examine a youngster whose eyes are damaged because of muscular dystrophy or degenerative or inherited diseases—things I can't correct. These are the times that I'd be happy to see a bunch of near-sighted kids."

Dr. Sowa has managed to be a doctor, wife and mother because, "We do mostly family-oriented things. We don't do many things that don't include the children."

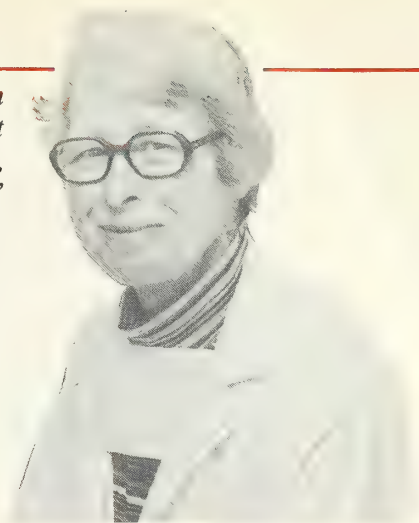
However, both she and her husband are members of the Musicians Club Chorus. "That," she said, "is our rest and relaxation."

In spite of a hectic family schedule—getting the children to and from their various activities, performing household chores, trying to maintain a balance between her practice and home life—Dr. Sowa, who has been practicing in Evansville since 1970, says of her career, "It's been very worthwhile, a very important part of my life."

Reprinted with permission of THE EVANSVILLE COURIER, Evansville, Ind. Stories and photos by Cissy Wastjer.

"There are many ailments that can be cured without surgery. It's just that I don't want to wait for weeks, even months, to see the results . . ."

Dr. Shirley Price



Surgeon Likes Immediate Results

SHIRLEY PRICE bounced into her office wearing blue jeans and a striped turtleneck sweater under her white doctor's jacket. Attached to her leather belt is the automatic paging device that summons her to respond to an answering service, no matter where she is on her rounds.

Dr. Shirley Price, physician and general surgeon at Welborn Clinic for 30 years, is the dean of practicing women doctors in Evansville.

A graduate of the University of Vermont, she did her residency at Hartford Hospital and at the New England Hospital for Women and Children. Earlier in her career she thought of specializing in plastic surgery, but dropped the idea because "straightening noses and taking out wrinkles was just too finicky and fussy for me."

General surgery appealed to her because "I am an impatient person," she said. "I like to see immediate results."

She conceded that doctors who prescribe medication for illnesses are very much needed, too. "There are many ailments that can be cured without surgery. It's just that I don't want to wait for weeks, even months, to see the results."

During her years as a surgeon, the 55-year-old woman has done operations ranging from gallbladder, stomach and breast surgery to some plastic surgery. She also has assisted in cardiovascular, heart and lung surgery.

She has seen a lot of improvements in every area of medicine and marvels at the progress made in diagnostic procedures, the tremendous step forward in anesthesiology, the miracles of open-heart surgery and replacement for gastrointestinal tracts, and the ability to predict the RH negative factor in unborn babies, which allows early treatment to prevent brain damage or death.

Dr. Price admits there might be some prejudice against women doctors, but adds that it has really never bothered her. "A patient's prejudice against a woman doctor is usually because that patient has not had any contact with the woman doctor."

She recalled a case where she operated on a man for a hernia. Several years later he came back to her—in all confidence—with another hernia.

"He told me he liked the way I had taken care of that first hernia and wanted me to operate on this one exactly the same way." Mulling over the incident, she noted, "Prejudice fades away with satisfactory results."

Turning to pages she had marked in a recent copy of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Dr. Price pointed out that the total enrollment of women in medical schools in the United States and Canada in 1959-60 was 1,700, or 5.7% of the student body. For 1976-77, the total number of women in 120 medical schools in the United States and Canada was 13,059, or 22%.

Another encouraging figure in the journal showed that 60% of women doctors today are 40 years old or younger. "This should tell you something," she said to emphasize her belief there will be more and more women physicians in the future.

What are the drawbacks of her profession? "Well, late night-time emergencies," she said, "after a hard day's work."

Then she added good-naturedly: "Even this isn't too bad when you consider that my work is intellectually stimulating, that every day is a little bit different, and that I am doing something to help others."



AUXILIARY REPORT

Ruth (Mrs. G. Beach) Gattman
President, ISMA Auxiliary

The Summer issue of the Hoosier Doctor's Wife introduced a new editor, Mrs. G. C. Laker (Marcia), Fort Wayne, and a new look. We hope you enjoy reading this informative quarterly publication as much as your spouse. It's an excellent method of communication between county and state auxiliary and exemplifies the quotation by James Matthew Barrie, "Those who bring sunshine to the lives of others cannot keep it from themselves." To complete our new look, the Winter issue will include information on how **you** can participate in selecting a new name for H.D.W. We welcome your suggestions. Since both male and female spouses of physicians are now members of the ISMA Auxiliary, our new name must reflect this change.

* * *

October 25-27, 1978 nine county presidents-elect will be attending the fourth AMA Auxiliary Leadership Confluence at the Drake Hotel, Chicago. Representing Indiana will be: Mrs. Patricia Laserna-Valena, Henry County; Mrs. Robert Sweeney, St. Joseph County; Mrs. Larry Sims, Vanderburgh Southwestern; Mrs. Fred Dallas, Marion County; Mrs. Peter Blickert, Allen County; Mrs. Gyorgy Polcy, Delaware-Blackford County; Mrs. Jay Tuttle, Knox County; Mrs. Harold Martin, Clark County; Mrs. Armand Fadul, Lake-Gary County; Marge Smith, AMA Auxiliary treasurer, Charlotte Bennett, president-elect, and myself.

Keynote speaker will be Dr. Tom E. Nesbitt, M.D., president, AMA. Included in the program will be James H. Sammons, M.D., and national program briefings on AMA-ERF, health projects, legislation and membership. Leadership seminars, designed to strengthen leadership abilities, will include Future Planning, Parliamentary Procedures, Priority Legislation, and

The Art of Public Relations. One of the highlights of the confluence will be the topic seminars, which will again feature outstanding faculty members. The seminars will include: Alcohol and the Teenager; Developing Healthful Lifestyles; Emergency Medical Services; Health Planning; The Hospice Concept; and Upgrading Jail Medical Care is Cost Effective.

The 250 participants representing county auxiliaries from throughout the United States will be exposed to the finest workshop experience available anywhere. The AMA Auxiliary should be commended for providing this outstanding service to the county auxiliary. We are delighted to have a full complement of delegates from Indiana. If your county auxiliary president-elect is represented at this confluence, why not ask her for her comments about the meeting? She'll be pleased to share her enthusiasm and knowledge of auxiliary with you.

* * *

Fall marks the beginning of a new county auxiliary year and traditionally brings invitations for the state president and president-elect to visit as many county auxiliaries as possible. This is the highlight of the year for me, as it gives me the opportunity to see auxiliaries in their own community and to learn about their many auxiliary programs and projects first hand. A special benefit was provided when I was privileged to visit the opening meeting of SAMS—Spouses of American Medical Students—and to participate in a panel discussion with three other physicians wives to discuss, "What It's Really like to be the Spouse of a Physician." With future members like these talented and lovely gals, the auxiliary will be in good hands.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. / mg. / mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



THE IMPAIRED PHYSICIAN:

A Treatable Problem

The problem of impaired physicians has been more widely recognized publicly and professionally during the past few years . . .

GERALD P. JOHNSTON, M.D.
Indianapolis

● *A surgeon, who had made rounds and operated repeatedly in an intoxicated state, came to the attention of the hospital staff officers in a large eastern hospital after he had become enraged when he found out that someone had done a tracheotomy on one of his surgical patients. He later found out that he had done the tracheotomy himself the night before while in an alcoholic blackout.*

● *An obstetrician from a large southwestern city had been hospitalized on six occasions with physical complications of alcoholism, injuries related to alcoholism, and two suicide attempts that had been overlooked or repeatedly covered up by his colleagues. He finally received treatment for his alcoholism and depression after he made his third suicide attempt while intoxicated.*

● *A 54-year-old white male with two previous one-car accidents was involved in a third accident in which his car ran off the road and was totaled. He received only minor injuries but was found to have a blood alcohol level of over 300 mg%. This is not an unusual case except that the accident occurred at 10 a.m., and the man was a busy family practitioner who was on his way to make rounds at a small hospital in a rural Indiana community. His frequent impairment from excessive drinking had repeatedly been overlooked or ignored by his family, friends, and associates.*

ALL OF THE ABOVE PHYSICIANS readily accepted treatment when they were finally confronted or offered treatment and have had successful results. Numerous other examples, most with successful eventual outcomes, could be cited where treatment was delayed because of lack of recognition, coverup, or fear to confront the individual. Unfortunately, when problems were recognized too late or covered up too long, the results may have included more serious medical and psychiatric complications, suicides, or, in a few cases, even harm to patients.

In the past thousands of physicians who have been suffering from alcoholism, other addictions, or disabling psychiatric problems were never confronted or referred for treatment. The problem of impaired physicians

has been more widely recognized publicly and professionally during the past few years, and organized medicine is now mounting an effort to seek and provide treatment for physicians with impairment related to alcoholism, addiction or psychiatric illness.

Thirty state medical societies have now set up committees charged with finding and aiding impaired physicians. The American Medical Association has also become actively involved in programs to help recognize and rehabilitate impaired physicians.

It is difficult to come up with any exact figures in regard to the number of impaired physicians, but the AMA has estimated that 5% of practicing physicians have some significant impairment from alcoholism, drug dependence or major psychiatric illness. Nationally, nearly 700 physicians are lost each year because of suicide, alcoholism, and drug addiction. To replace these physicians, six gradu-

The author is chairman, Impaired Physician Peer Review Committee, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

ating classes from an average-sized medical school, or more than two classes from a medical school the size of Indiana University School of Medicine, would be required.

The AMA has recognized the increasing problem of losing productive physicians due to varying types of impairment, and recently has taken steps to offer programs that would lead to early recognition and rehabilitation of impaired physicians. The AMA has sponsored three national meetings on impaired physicians. The first was in San Francisco in 1975 and was entitled "The Disabled Doctor, a Challenge to the Profession." The second meeting was held in February 1977 in Atlanta and was entitled "The Impaired Physician, Answering the Challenge." The third conference was held in September 1978 in Minneapolis with specialized programs on high-risk groups, hospital-based rehabilitation programs, and legal aspects of impaired physician programs.

The AMA also has written a model act that can be used as a guideline for legislation regarding impaired physicians. They have recently been publishing a newsletter on the impaired physician. Approximately 30 state medical associations have developed programs to help recognize and rehabilitate impaired physicians. These programs vary from completely voluntary to programs with coercive backup. Programs which are on a purely voluntary basis appear to have more referrals, whereas the programs that have some coercive backup appear to be more effective in actually getting impaired physicians into treatment that leads to more complete rehabilitation.

The Impaired Physician Peer Review Committee of the Indiana State Medical Association was established in 1977 when Dr. John Beeler, 1976-77 president of ISMA, appointed an Ad Hoc Committee on the impaired physician because of the recognized need for organized medicine to take a more active role in attempting to rehabilitate physicians with problems. He felt that medicine needed to protect the public from the impaired physician, prevent loss of important medical manpower, and help the impaired physician regain health and happiness. At the annual meeting in 1977, the house of delegates established the Impaired Physician Committee as a permanent committee of the Indiana State Medical Association. The committee has met on a regular basis to establish goals and objectives and develop a program for recognition, evaluation, and rehabilitation of impaired physicians. In 1978, Dr. Eli Goodman, 1977-78 president of ISMA, appointed a representative from each district to form an advisory committee to assist de-

veloping programs on the local level.

An exhibit on the impaired physician program was presented at the 1977 annual meeting and a two-hour program on impaired physicians, featuring nationally recognized experts, was presented at the 1978 Indiana State Medical Association's annual meeting last month.

The goals of the Impaired Physician Committee are to: (1) improve the quality of medical care and promote a more positive image of physicians in Indiana by developing programs for early recognition, referral and rehabilitation of physicians impaired by alcoholism, drug abuse, neuropsychiatric illness, or physical infirmity, and (2) to assist in the prevention of permanent disability and loss of license in susceptible physicians by helping local societies provide education, recognition, evaluation, referral, rehabilitation and re-entry services for impaired physicians.

Organized medicine is now mounting an effort to seek and provide treatment for physicians with impairment related to alcoholism, addiction or psychiatric illness . . .

The mechanism for referral and processing of requests for assistance in regard to impaired physicians is outlined in the brochure on the impaired physician, available through the ISMA headquarters. Physicians may be referred on an informal basis by themselves, family, friends or colleagues. An initial contact will be made by a regional screening committee member and evaluation and referral for treatment made if indicated.

If a physician refuses voluntary treatment and has continuing problems, a formal referral may be made to the Impaired Physician Committee. Such referral will be considered a formal or official contact and will be reviewed by at least two local screening committee members, at least one of whom would make personal contact with the referred physician. If the screening committee members determine treatment is necessary, referral for treatment and arrangements for follow-up will be made. The case will be closed when confirmation has been received that treatment is completed.

If the physician who has been referred on a formal contact or complaint refuses treatment or does not complete treatment, and if the screening committee recommends required treatment, the case will be referred to the ISMA's Examining Committee, which will evaluate the case, request personal appearance of the physician when indicated, and determine if required treatment or referral to the state

licensing board is indicated.

If the physician then accepts treatment, the case will be closed when confirmation that treatment was completed is received.

If the physician refuses or does not complete required treatment, referral to the county grievance committee or state licensing board for appropriate action will be recommended. If official action is taken by the licensing board or grievance committee, the physician may be referred back to the examining or screening committee for monitoring and follow-up.

During the first year of operation, the committee has received many contacts regarding possibly impaired physicians, and several physicians have been successfully referred for evaluation, treatment and rehabilitation. In some cases, the referred physician has shown marked improvement in his behavior and functioning following an interview with a member of the committee, and treatment has not been necessary. In other instances, in-patient treatment with follow-up out-patient care has been needed. The most common problem referred to the committee has been in regard to physicians with apparent alcoholism or periodic impairment from excessive use of alcohol.

A concerned colleague who is willing to approach a problem physician can often be a strong motivating and supportive force to resolve problems or seek treatment . . .

The Peer Review Committee on the Impaired Physician encourages handling problems with impaired physicians on a local level if possible. A concerned colleague who is willing to approach a problem physician can often be a strong motivating and supportive force to resolve problems or seek treatment when necessary. If problems persist, assistance of hospital staff officers, credentials committees or county medical society representatives may help resolve the problem. If problems remain unresolved, referral to a local screening committee representative for assistance, evaluation, and referral for treatment is indicated. If a physician with obvious and persistent problems is resistant to getting needed assistance, formal referral may be made through the local screening committee member or directly to the Indiana State Medical Association or a member of the Peer Review Committee on the Impaired Physician. Referrals to private psychiatrists or other interested physicians for treatment is encouraged.

Additional treatment resources and other

guides to getting assistance are available in the ISMA brochure on the impaired physician mentioned above. Additional information concerning obtaining assistance for apparently impaired physicians and a list of the permanent committee and advisory committee members is also available from the ISMA headquarters. Brochures and additional information may be obtained by contacting the Indiana State Medical Association (WATS 1-800-382-1721).

REFERENCES

1. AMA Council on Mental Health: The sick physician (impairment by psychiatric disorders, including alcoholism and drug dependence). *JAMA*, 223(6): 684-687, Feb. 5, 1973.
2. AMA Dept. of Mental Health: Helping the impaired physician. *Report of conference*, February 1977.
3. AMA Dept. of Mental Health: The impaired physician. *Report of Conference*, April 1975. (Available from AMA Dept. of Mental Health)
4. Bissell, L and Jones, RW: The alcoholic physician: A survey. *The American Journal of Psychiatry*, 133(10): 1142-1146, October 1976.
5. Bissell, L and Mooney, AM: The special problem of the alcoholic physician. *Medical Times*, 103(6): 63, June 1975.
6. Bittker, TE: Reaching out to the depressed physician. *JAMA*, 236(15): 1713-1716, Oct. 11, 1976.
7. Bloom, Mark: Impaired physicians: Medicine bites the bullet. *Medical World News*, July 24, 1978.
8. The impaired physician: A treatable problem. *ISMA Impaired Physician Peer Review Committee*, September 1978.
9. Kosbab, P: Suicide prevention in physicians. *The New Physician*, 21(1): 21-23, January 1972.
10. Litman, RE: Suicide of physicians: Why does it happen and can it be prevented? *Modern Medicine*, 42(11): 34, May 27, 1974.
11. Miller, Marvin: How we can help the suicidal physician. *Medical Economics*, Jan. 23, 1978.
12. New help for disabled physicians. *The Ohio State Medical Journal*, 71: 641-644, September 1975.
13. The OSMa physician effectiveness program (8 articles). *The Ohio State Medical Journal*, November 1977.
14. Small, IF, Small, JG, Assue, CM and Moore, DF: The fate of the mentally ill physician. *The American Journal of Psychiatry*, 124(10): 1333-1342, April 1969.
15. Suicidal physicians: Problem patients. *Medical World News*, 17(18): 58, Aug. 23, 1976.
16. Talbott, GD, Holderfield, H, Shoemaker, KE, Atkins, EC: The disabled doctors plan for Georgia. *Journal of Medical Association of Georgia*, 65(3): 71-76, March 1976.
17. Waring, EM: Psychiatric illness in physicians: A review. *Comprehensive Psychiatry*, 15(6): 519-530, November/December 1974.
18. Watterson, DJ: Psychiatric illness in the medical profession: Incidence in relation to sex and field of practice. *Canadian Medical Association Journal*, 115: 311-317, Aug. 21, 1976.
19. Whieldon, David: Drinkers, addicts, depressives: What happens when they are doctors. *Practical Psychology for Physicians*, pp 13-26, November 1977.

The Great Laxative Escape



COLACE

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson

PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company, Evansville, Indiana 47712 U.S.A. 678

This asthmatic isn't worried about his next breath...

he's active
he's effectively
maintained on

QUIBRON[®]

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Merabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL B-4294R

THE JOURNAL, in cooperation with the Division of Postgraduate and Continuing Medical Education of the Indiana University School of Medicine, offers its readers a Continuing Medical Education program. This is the 11th in a series of CME articles, produced by the faculty of the School of Medicine and is supported by a grant from its Division of Postgraduate and Continuing Medical Education.

As an organization accredited for continuing medical education, the Indiana University School of Medicine certifies that this continuing medical education activity meets the criteria for 1 credit hour in Category I for the Physician Recognition Award of the American Medical Association provided it is used and completed as designed.

To obtain Category I credit, complete the quiz on Page 1082.



Practical Management of Diabetes for Family Practitioners

CHARLES M. CLARK, JR., M.D.
Indianapolis

I WOULD LIKE to approach the practical management of the diabetic patient by the family practitioner by looking at five critical decision points in his care, and by examining how the family practitioner should approach these critical decisions.

The author is a professor of Medicine and Pharmacology and Director of the Diabetes Research and Training Center, Indiana University School of Medicine. He also is Chief, Diabetes Service, Veterans' Hospital, Indianapolis.

This article was prepared as part of the translation mission of the Diabetes Research and Training Center (PHS P60 AM 20542.), Indiana University School of Medicine.

Acknowledgement: The review of this paper by F. Vinicor, M.D., and S. E. Fineberg, M.D., and the manuscript preparation by Ms. Claudia VanNoy are appreciated.

1. Does the patient have diabetes?

We cannot discuss the diagnosis of diabetes mellitus without making some practical decision about what we are going to do after we get the blood sugar back. Obviously, a patient with markedly elevated blood sugars who is symptomatic with glucosuria will need treatment as discussed below. A fairer question to ask is what do we do with patients with mild abnormalities in glucose tolerance. We can divide patients arbitrarily into those who have normal and those who have abnormal fasting blood sugars. In general, patients with normal fasting blood sugars do not require treatment (except in the obese). Those with abnormal fasting blood sugars generally require additional therapy.

When you want to make a diagnosis of diabetes mellitus you have to consider both sensitivity and specificity. Postprandial blood sugars, particularly the two-hour value, are quite sensitive. They will diagnose people with mild abnormalities in carbohydrate metabolism which require little or no treatment. The best use of the postprandial blood sugar is in someone who has a normal fasting blood sugar in evaluation of cardiovascular risk factors. There is no question that there is a direct relationship between the incidence of coronary artery disease and other cardiovascular disease and postprandial blood sugars. The higher your postprandial blood sugar the more likely you are to develop angina, myocardial infarction, and peripheral vascular disease. It is not, however,

a good indicator of whether or not the patient needs treatment.

For the diagnosis of the patient who may require therapy, the fasting blood sugar is much more reliable. The fasting blood sugar is fairly constant from day to day in a given patient, and two fasting blood sugars above 110 mg% in an otherwise healthy patient makes the diagnosis of diabetes mellitus. Patients with a potential for developing diabetes mellitus may have elevated fasting blood sugars in the presence of concomitant diseases. These patients probably warrant re-evaluation once their acute illness is over. Long-term studies in groups of patients such as this suggest that the subsequent development of diabetes mellitus varies depending on the height of the blood sugar. With fasting blood sugars above 300 mg%, they will almost invariably develop diabetes. With fasting blood sugars in the 110 to 150 range, however, only about 10-15% will go on to develop clinical diabetes.

We do not recommend the glucose tolerance test for the diagnosis of diabetes. Although it is a good epidemiologic test, it is too variable in any single patient to be relied upon. A variety of stresses will make glucose tolerance abnormal. These include any acute illness, pregnancy, bed rest itself, and trauma. In addition, a variety of medications can make glucose tests abnormal including Dilantin®, thiazide diuretics, and oral contraceptives.

For a glucose tolerance test to be meaningful, a patient must be in his usual state of health, an outpatient, and on no medications. This means for all practical purposes, that a glucose tolerance test performed in a hospitalized patient is of no value in the diagnosis of diabetes. This does not mean that you cannot diagnose diabetes with a glucose tolerance test. Rather, what it means is that the simpler procedures discussed above will give you the same information at less cost and inconvenience to the patient.

► In summary, a glucose tolerance test is of little or no value in the diagnosis of diabetes. Fasting blood sugars most accurately diagnose diabetes particularly in the otherwise healthy individual. Post prandial blood sugars will predict the development of cardiovascular disease and will identify those patients at risk, but are not a good indicator for the treatment of diabetes mellitus.

2. Does the patient need a special diet?

The answer to this question almost invariably is yes; the patient needs a special diet but the diet the patient needs varies. First of all, approximately 80% of adult patients will be overweight. The special diet that an overweight patient needs is restriction in calories. If he has a normal fasting blood sugar there is no particular reason to place him on American Diabetes Association diet or any carbohydrate restricted diet. The best diet for this individual is one restricted in calories, but otherwise close to a normal American diet as possible. The diet should be designed so that the patient loses approximately one pound a week; a diet of 15 calories per kilogram will achieve this in the normally active patient.

The second group of individuals have increased fasting blood sugars. In these patients carbohydrate restriction has been traditional. The most accepted diet for these patients is the American Diabetes Association Exchange diet. This diet contains approximately 45% carbohydrate and restricts concentrated carbohydrates such as sugar, syrup, etc. The diet has the advantage of being easily taught and is in constant use. Exchange values for a variety of processed foods are available and the patient can usually learn this diet with about 2 to 3 hours of instruction by a dietitian. Unfortunately, there is little scientific evidence that the blood sugars of stable adult onset diabetics will be better controlled on this diet than they would be on a diet relatively high in carbohydrates. Several

recent studies have demonstrated that high carbohydrate or high carbohydrate/high fiber diets will control adult onset diabetics as well (and in some instances better) than a carbohydrate restricted one.

This becomes important when patients have concomitant lipid problems in addition to diabetes mellitus. About one-third of diabetic patients will have increased triglycerides. In these patients, weight reduction and a lowering of dietary lipids is recommended. The American Diabetes Association diet is high in lipid (approximately 35%); in patients with hypertriglyceridemia, we should liberalize carbohydrates in order to reduce fats.

We recommend the ADA Exchange Diet for patients who have mild abnormalities. Patients with lipid abnormalities should have more liberal carbohydrates and reduction in fats to 20% from 25%. Unsaturated fats should constitute 50% of the fat intake, and cholesterol intake should not exceed 250 mg. per day.

The family practitioner should be aware that diet is under review and that carbohydrate content of diabetic diets may be significantly increased within the next few years.

► In summary, in patients with mild carbohydrate abnormalities, the single most important dietary treatment is reduction in calories and weight loss. In those patients who have increased fasting blood sugars, a carbohydrate restricted diet such as the American Diabetes Association diet is recommended. I cannot stress enough, however, the importance of dietary education. In our clinic, we avoid the addition of oral agents or insulin until we are sure that either they are on the diet or that there is little or no chance that they will change their dietary habits. Even in these cases, we constantly review the patient's family situation and emotional stability to see whether or not the patient has now become able to accept a dietary regimen.

There are several studies suggesting that short term fasts in the hos-

pital can be used to initiate dietary therapy in these patients. The long-term results of such fasting in the diabetic patient are as yet unknown. In the non-diabetic obese patient over an 18-month to three-year period, fasting is no more successful than traditional dietary therapies.

3. Does the patient need insulin or oral agents?

The answer is not as simple as it might seem. We all realize that the single most important form of treatment of diabetes mellitus is diet. We also all realize that dietary failures are common and perhaps the rule.

Once we have a patient who is on whatever diet he is willing to follow (frequently less than ideal), then we have to decide at what point we are going to add further agents and what agents we are going to use. There is a considerable body of scientific evidence suggesting that mean blood sugars over a 24-hour period (approximated by the fasting blood sugar) of 200 mg% or greater are associated with a significantly increased incidence of small vessel complications (diabetic microangiopathy). We will discuss this further below. We conclude from this that careful control of the juvenile diabetic is warranted.

The decision here, however, is relatively clear since virtually all juveniles require insulin. The situation in the adult is less clear. As discussed below, control of blood sugar *per se* has not been shown to prevent macrovascular disease, the cause of death of the majority of adult patients. Any decision to initiate insulin or oral agents in this group will, therefore, be to a certain extent arbitrary. We believe that adult patients who have fasting blood sugars above 180 mg% and/or who are symptomatic on diet can be placed on oral agents, and most will respond with the lowering of blood sugar. Whereas there is no scientific evidence suggesting that these patients will have a decreased incidence of development of cardiovascular lesions, the incidence of small vessel lesions should be decreased.

► Most of our patients are placed on insulin therapy. Part of the reason may be that most of our patients are referred after oral agents fail. Another reason may be that since we stress diets and work with the patient with diet for extended periods, we are perhaps more successful with diet than the individual practitioner with more limited resources. When we have a dietary failure, the patients fasting blood sugars are usually quite elevated and they do not respond well to oral agents.

The practitioner should be aware that there is considerable controversy regarding the oral agents. This has been generated by the UGDP study, the results of which suggested no benefit and possible harm from oral agents. Whereas we are not convinced by this study of the harm of oral agents, we cannot take much solace from the failure of the treated patients to do well. These data have convinced us that control of the blood sugar in the adult patient is not adequate; that other risk factors must be sought out and adequately treated if we are going to have any significant reduction in cardiovascular morbidity.

4. Does the patient need treatment for other problems?

The purpose of treatment of diabetes mellitus is to alleviate symptoms and acute complications and to prevent the long-term complications of diabetes mellitus. There is increasing evidence suggesting that the small vessel (microvascular) complications of diabetes mellitus are a direct consequence of the metabolic abnormalities. Experimental animal work and a few controlled studies in man suggest that the nearer the blood sugar is to normal the less likely small vessel lesions are to develop. The rate of development of microvascular disease is also slower in well controlled patients. We believe that a major objective of the treatment of diabetes mellitus with diet and insulin is the prevention of small vessel disease.

Most adult patients with diabetes mellitus do not die of small vessel disease, but large vessel disease (macroangiopathy). Family practitioners will be seeing mostly the adult onset diabetic who falls into this category. We know that 75% of these patients will die of large vessel disease and most of these from myocardial infarctions. We also know the incidence of cardiovascular disease is increased approximately 4 times in men and approximately 12 times in women who have diabetes over the general population.

There are, however, problems in determining why this is true. Diabetic patients frequently have more than one cardiovascular risk factor. They have an increased incidence of obesity, hypertension, and lipid abnormalities. All of these factors are associated with increased risk of cardiovascular disease. When analyzed in large epidemiologic studies, the risk of diabetes itself is small compared to the risk of these other factors and decreases with the age of the patient.

Additionally, the risk of developing cardiovascular disease in diabetics varies among cultures. In studies of Japanese and Indian diabetics, the incidence of heart attacks and other large vessel diseases among diabetics is no higher than the general population, and much lower among these cultures than among non-diabetic Americans. It is extremely important, therefore, that all adult patients with diabetes mellitus be evaluated for baseline cardiovascular status and specifically evaluated for obesity, hypertension, hyperlipidemia, smoking and exercise status. If abnormalities are found, they should be vigorously treated.

There is a close relationship among obesity, diabetes, hypertension, and hyperlipidemia. In general, the treatment of these risk factors is the same—weight loss. Smoking increases the risk for sudden death and increases the symptoms and severity of peripheral vascular disease. It should be prohib-

ited in diabetics. There is increasing interest in exercise and cardiovascular disease. Those who have good cardiovascular exercise training have decreased incidence of myocardial infarctions and sudden deaths over those who do not.

► We conclude that patients with diabetes mellitus must be evaluated for all risk factors and they must all be adequately treated if we are to lower the chance of developing cardiovascular disease. We also conclude that there is no scientific evidence that lowering blood sugar by itself will decrease the chances of patients developing large vessel disease. In fact, only the lowering of blood pressure has been conclusively demonstrated to decrease the risk of development of cardiovascular complications.

5. Does the patient need to be referred to a specialist?

a. *All patients with juvenile onset diabetes mellitus should be referred to a specialist for initial evaluation and education.* The lack of facilities in most institutions for appropriate patient and family education make this referral imperative. Diabetes is a lifetime disease; there is significant evidence that treatment patterns established in the first years of the disease will influence the course of the disease significantly. The attitude of the patient toward his disease and, therefore, his cooperation, and the likelihood of preventing complications depend upon this early period. The importance of adequate family and patient education cannot be overemphasized. Thus the newly diagnosed juvenile diabetic should be referred to a specialist specializing in patient education and diabetic care. The patient should then be cared for by the family practitioner working with the specialist. The frequency of specialists's visits will vary, depending on the complexity of the patient.

We also recommend camps for juvenile patients with diabetes mellitus. The American Diabetes Association, Indiana affiliate, has a large active youth program for diabetic patients. It is very important

for juveniles with diabetes mellitus to know other patients with diabetes so that they may realize that the difficulties that they have can be overcome and they can lead a normal life.

b. *The patient is not responding to treatment.* We set a fasting blood sugar goal of 180 mg% as the highest fasting we will tolerate. We consider good control fasting blood sugars, between 120-150 mg% and preprandial blood sugars between 150-180 mg%. If these goals are not achieved, then it is reasonable to have patients seen by a specialist to determine what problems are inherent to the patient's diabetes and what problems could be improved by changes in his treatment regimen. Generally, this referral will require a hospitalization. For the juvenile diabetic a camp experience may be substituted.

c. *The patient has developed complications.* Many of the complications of the diabetes mellitus can be treated, particularly when detected early. We will divide the discussion into small vessel disease and large vessel disease.

The development of retinopathy should be looked for and promptly referred. Treatment with laser beam therapy gives significant improvement. Patients with juvenile onset diabetes, particularly those who have had diabetes for longer than 12 years, should have their retinas examined at each visit and visual acuity measured. The development of new vessels or a decreased visual acuity should prompt immediate referral.

The development of neuropathy also suggests a specialist consultation. Most neuropathic symptoms are self limiting, but neuropathy can be occasionally debilitating. We particularly wish to point out the problem of impotence in the diabetic patient. About 50% of the male diabetic patients with diabetes for more than 10 years will be impotent and this number will rise to approximately 80% by the end of 15 years of diabetes. The patient will not complain of this because of embarrassment. They must be asked.

This complication can be treated with counseling and, occasionally, a prosthesis.

The development of renal disease with the onset of proteinuria or azotemia should suggest patient referral. These patients have a very rapid course once abnormal BUNs occur with an average duration of life of less than 5 years. Careful control of diabetes mellitus and particularly hypertension can delay the development of this terrible complication and renal transplantation seems to be becoming more practical in this group of patients.

The development of peripheral vascular disease suggests referral for appropriate treatment. This is manifested by bruits, claudication or decreased peripheral pulses.

d. *Foot lesions.* About one-third of the admissions of patients with diabetes mellitus are for foot lesions. Most of these could be prevented. The foot lesions are of two types; those which occur in the presence of neuropathy because the feet are basically anesthetic and those which occur with peripheral vascular disease because of insufficient blood supply.

In both cases, being aware of the problem and proper preventative foot care by either the family practitioner or the local podiatrist can prevent many of these lesions. It has been my own view that it is much more important to look at the patient's feet than it is to listen to his heart.

e. *The patient should be referred to a specialist when the other complications or concomitant risk factors are not adequately controlled; these would include treatment of hyperlipidemia or hypertension.*

► In summary, the majority of patients with diabetes mellitus can be managed in the family practitioner's office. General principles are the use of diet and the setting of goals of therapy. The juvenile diabetic patient's life can likely be significantly prolonged by full attention to metabolic control. The adult onset diabetic patient's life can be prolonged in general by re-

ducing the risk factors, including the treatment of blood sugars, but more importantly, reduction of weight, hypertension, hyperlipidemia and smoking. In addition, foot lesions in the diabetic patient are usually preventable with careful attention to good foot care.

REFERENCES

I. Macrovascular Disease

1. Kannel, W B: Recent findings of the Framingham study. *Resident and Staff Physician* 24:56-76, 1978.
2. Gordon, T, Castelli, SP, Hjortland, MD, *et al*: High density lipoprotein as a protective factor against coronary heart disease: The Framingham Study. *Am J Med* 62:707-714, 1977.
3. Kannel WB, Hjortland, MD, Castelli, WP: Role of diabetes in congestive heart failure: The Framingham Study. *Am J Cardiol* 34:29-34, 1974.
4. Keen, H, Jarrett, RJ: Macroangiopathy—its prevalence in asymptomatic diabetes. *Vascular & Neurological Changes in Early Diabetes*. Edited by Rafael A. Camerini-Davalos and Harold S. Cole. Published by Academic Press, Inc. (London) LTD., London, England: pp. 3-9, 1973.
5. Garcia, M, McNamara, P, Gordon, T, Kannel, WB: Cardiovascular complications in diabetes. *Vascular & Neurological Changes in Early Diabetes*. *ibid*: pp. 493-499, 1973.

II. Microvascular Disease

6. Cahill, GF, Jr, Etzwiler, DD, Freinkel, N: Control and diabetes. *The New England J of Med* 294:1004-1005, 1976.
7. Siperstein, MD., Foster, DW, Knowles, HS, Fr., Levine, R, Madison, LL, Roth, J: Control of blood glucose and diabetic vascular disease. *The New England J of Med* 296:1060-1063, 1977.
8. Jarrett, RJ, Keen, H: Hyperglycemia and diabetes mellitus. *The Lancet*: pp. 1009-1012, November 1976.

III. Prevention

9. Prout, TE: Therapy of early diabetes: The University Group Diabetes Program. *Vascular & Neurological Changes in Early Diabetes*. Edited by Rafael A. Camerini-Davalos and Harold S. Cole. Published by Academic Press, Inc. (London) Ltd, London, England: pp. 501-520, 1973.
10. Keen, H, Jarrett, RJ, Ward, JD, Fuller JH: Borderline diabetics and their response to tolbutamide. *Vascular & Neurological Changes in Early Diabetes*. *ibid*: pp. 521-531, 1973.
11. Keen, H, Jarrett, RJ, Chlouverakis, C, Boyns, DR: *Postgrad Med J* 44: 960, 1968.

12. Paasikivi, J: Long-term treatment of patients with abnormal intravenous glucose tolerance after myocardial infarction. *Vascular & Neurological Changes in Early Diabetes*. Edited by Rafael A. Camerini-Davalos and Harold S. Cole. Published by Academic Press, Inc. (London) LTD., London, England: pp. 533-538, 1973.
13. Marble, A: Vascular disease in diabetes and the effect of oral antidiabetic agents. *Vascular & Neurological Changes in Early Diabetes*. *ibid*: pp. 539-547, 1973.
14. Marble, A: *Diabetes* 16: 825, 1967.

NEUROPATHY IN DIABETES MELLITUS

I. General Clinical Aspects

1. Ellenberg, M: Diabetic neuropathy: Clinical aspects. *Metabolism* 25:1627-1655, 1976.
2. Lawrence, A: Diabetic neuropathy—A review. *The Annals of Clinical and Laboratory Sciences* 6:78-83, Jan-Feb., 1976.
3. Anderson, JW: Metabolic abnormalities contributing to diabetic complications. II. Peripheral nerves. *The Am J of Clin Nutrition* 29:402-408, 1976.

II. Metabolic Studies in Diabetic Neuropathy

4. Anderson, JW: Metabolic abnormalities contributing to diabetic complications. II. Peripheral nerves. *The Am J of Clin Nutrition* 29: 402-408, 1976.
5. Gabbay, KH: The sorbitol pathway in the complications of diabetes. *New England J of Med* 288:831-836, 1973.
6. Ward, JD, Baker, R, Davis, B: Effect of blood sugar control on the accumulation of sorbitol and fructose in nervous tissue. *Diabetes* 21: 1163-1178, 1972.
7. Winegrad, A, Greene, D: Diabetic polyneuropathy: The importance of insulin deficiency, hyperglycemia and alterations in myoinositol metabolism in its pathogenesis. *New England J of Med* 295:1416-1421, 1976.

III. Clinical Studies in Diabetic Neuropathy

8. Editorial: Structure and function in diabetic autonomic neuropathy. *British Med J*: pp. 544, March 6, 1976.
9. Editorial: Painful diabetic neuropathy. *British Med J*: pp. 349, Aug. 6, 1977.
10. Fraser, D, Campbell, I, Ewing, D, *et al*: Peripheral and autonomic nerve in function in newly diagnosed diabetes mellitus. *Diabetes* 26: 546-550, 1977.
11. Editorial: Diabetic neuropathy: A preventable complication. *The Lancet*: pp. 583-584, Sept. 16, 1972.

12. Ward, J, Fisher, D, Barnes, C, *et al*: Improvement in nerve conduction following treatment in newly diagnosed diabetics. *The Lancet*: pp. 428-430, Feb. 27, 1971.
13. Braddom, R, Hollis, J, Castelli, D: Diabetic peripheral neuropathy: A correlation of nerve conduction studies and clinical findings. *Arch of Phys Med & Rehab* 58:308-313, 1977.
14. Gregersen, G: Variation in motor conduction velocity produced by acute changes of the metabolic state in diabetic patients. *Diabetologia* 4: 273-277, 1968.

DIET

1. West, KM, Kalbfleisch, JM: Influence of nutritional factors on prevalence of diabetes. *Diabetes* 20:99-108, 1971.
2. Kahn, CR, Soll, AH, Neville, DM, Goldfine, ID, Archer, JA, Gorden, P, Roth, J: The insulin receptor in obesity and other states of altered insulin sensitivity. *Obesity in perspective. Fogarty International Series on Preventive Medicine*, Vol 2, Part 2, pp. 301-311. U.S. Government Printing Office, Washington.
3. Allen, FM, Fitz, R, Stillman, E: Total dietary regulation in the treatment of diabetes. *Bulletin 11*. Rockefeller Institute for Medical Research, 1919.
4. Davidson, JK: Educating diabetic patients about diet therapy. *Bulletin* 20, No. 2. International Diabetes Federation. May 1975, pp. 3-7.
5. Prout, TE: Adverse effects of the oral hypoglycemic drugs. *Proceedings of the Eighth Congress of the International Diabetes Federation*, 1974, pp. 612-623.
6. Davidson, JK: The FDA and hypoglycemic drugs. *JAMA* 232:853-855, 1975.
7. Davidson, JK: Controlling diabetes mellitus with diet therapy. *Postgraduate Medicine* 59:114-122, 1976.
8. Hamwi, GJ: Therapy: Changing dietary concepts. *Diabetes Mellitus: Diagnosis and Treatment*. Edited by T.S. Danowski. New York, American Diabetes Association, Inc., 1:73-78, 1964.
9. Weinsier, RL, Seeman, A, Herrera, MG, Simmons, JS, Collins, ME: Diet therapy of diabetes: Description of a successful methodologic approach to gaining diet adherence. *Diabetes* 23:669-673, 1974.
10. Davidson, JK, Goldsmith, MP: *Diabetes Guidebook: Diet section*. Ed. 2, Columbus, Ga., The Litho-Krome Co., 1972.
11. *Exchange Lists for Meal Planning*, 1976. American Diabetes Association, New York.
12. Davidson, JK: Unpublished observations.

Immunoblastic Lymphadenopathy

SWEI H. TSUNG, M.D.
Gary

IMMUNOBLASTIC LYMPHADENOPATHY¹ or "Angioimmunoblastic Lymphadenopathy with dysproteinemia"² is an atypical lymphoproliferative disorder that appears to be a non-specific reactive process to as yet unknown agents. Awareness of this new entity is important for two reasons:

- It may be histologically confused with Hodgkin's disease.
- The experience with cytotoxic drug therapy suggests that chemotherapy is not only ineffective, but may become harmful, enhancing the patient's susceptibility to infection.³

This paper presents a typical case of immunoblastic lymphadenopathy to demonstrate its morphology, clinical symptoms and biological behavior.

CASE REPORT

A 69-year-old white woman was seen in March 1975 with a "Flu-like" syndrome and enlarging masses in axillary and inguinal regions. She responded to antibiotic therapy. She was hospitalized in January 1976 with fever and recurrent lymphadenopathy. Past history revealed that she was allergic to IVP dye.

Physical examination showed lymph node enlargement in both inguinal and axillary regions. Laboratory data on the first admission included: hemoglobin 9.1 gm. per 100 ml, hematocrit reading 28%, leukocyte count 11,200 per cu.mm. The differential was: polymorphonuclears 76%, lymphocytes 15%,

monocytes 3% and eosinophils 6%. Serum levels of total protein was 7.5 gm. per 100 ml, with serum globulin of 4.5 gm. per 100 ml. The direct Coomb's test was positive. Her chest x-ray showed anterior and superior mediastinal masses.

The cervical lymph node biopsy was performed. Normal architecture of the lymph node was completely obliterated by a polymorphic cell infiltrate that included lymphocytes, immunoblasts, branching capillaries, plasma cells and many transitional cell forms. (*Figures 1 & 2*).

In some areas there were large masses of amorphous eosinophilic material resembling fibrin that was usually deposited in the wall of the

vessels or lay freely in the extrasinusoidal space (*Figure 3*).

The diagnosis of immunoblastic lymphadenopathy was established. Immunodiffusion showed: IgG 2,370 mg. per 100 ml (normal: 780-1,800 mg. per 100 ml) IgA 204 mg. per 100 ml (normal 68-250), IgM 603 mg. per 100 ml (normal: 67-208).

There was no Bence-Jones protein in the urine. Serum protein electrophoresis showed polyclonal gammopathy. The liver and spleen scan showed hepatosplenomegaly.

The patient was then transferred to University of Chicago Medical Center for further evaluation. It was decided not to treat the primary disease at that time. She was sent home on ampicillin for a possible

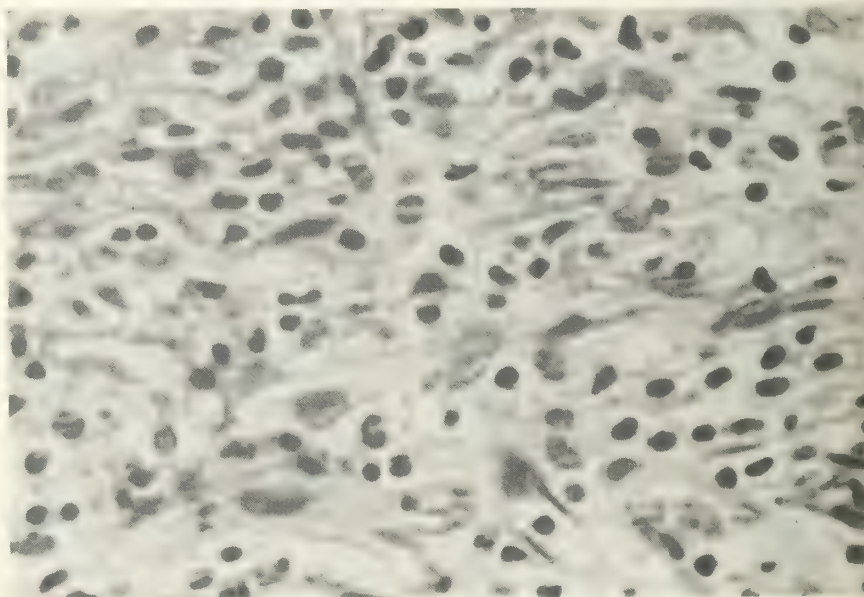


Figure 1

Polymorphous infiltrate with prominent immunoblasts, plasma cells, and lymphocytes. (Hematoxylin and eosin; x400)

From the Department of Pathology, Methodist Hospital of Gary, Inc. Gary, Ind. 46402.

urinary tract infection.

The patient was readmitted three weeks later, because of temperature elevation to 105F. During her hospital stay, she developed bilateral pleural effusions and ascites. Extensive work-up for infection in-

cluded: culture from bone marrow, blood, spinal fluid, peritoneal and pleural fluid yielded negative results. She was on gentamycin and chloramphenicol. The patient's temperature finally abated on the eighth day of her hospital stay. Her pleural

effusions and ascites disappeared. She was discharged and readmitted one week later.

On her final admission, she appeared obtunded, dehydrated and in no acute distress. It was during this admission that the patient began receiving azathioprine in addition to antibiotics and prednisone. She was noted to have *Candida albicans* infection of the urinary tract. The hospital course was one of gradual deterioration. She died April 25, 1976.

At autopsy, she was found to have generalized lymph node enlargement due to immunoblastic lymphadenopathy, which also involved spleen, liver, thyroid, kidneys, bone marrow and lungs. Her demise was attributed to bilateral bronchopneumonia.

DISCUSSION

The pathogenesis of immunoblastic lymphadenopathy is unknown. Frizzera, *et al*² believe that it is not a malignant process. Lukes and Tindle¹ stress the possible importance of hypersensitivity to therapeutic agents. Several reports describe the dramatic onset of the disorder following administration of various therapeutic agents including penicillin, griseofulvin, phenytoin (Dilantin®), sulfonamides, aspirin, halothane and primidone.^{2,4,5}

In one case, the disease developed after prolonged therapy with liver extract, and antiliver extract antibodies were found in the serum.⁶ In another case, a rubella infection preceded the onset of the disorder by three months.⁷

Immunoblastic lymphadenopathy differs from Hodgkin's disease in the absence of classical Reed-Sternberg cells. Another important feature is that Hodgkin's disease only seldom has the background of many arborizing hyperplastic capillaries. Non-Hodgkin lymphoma usually is

CONTINUED ON PAGE 1086

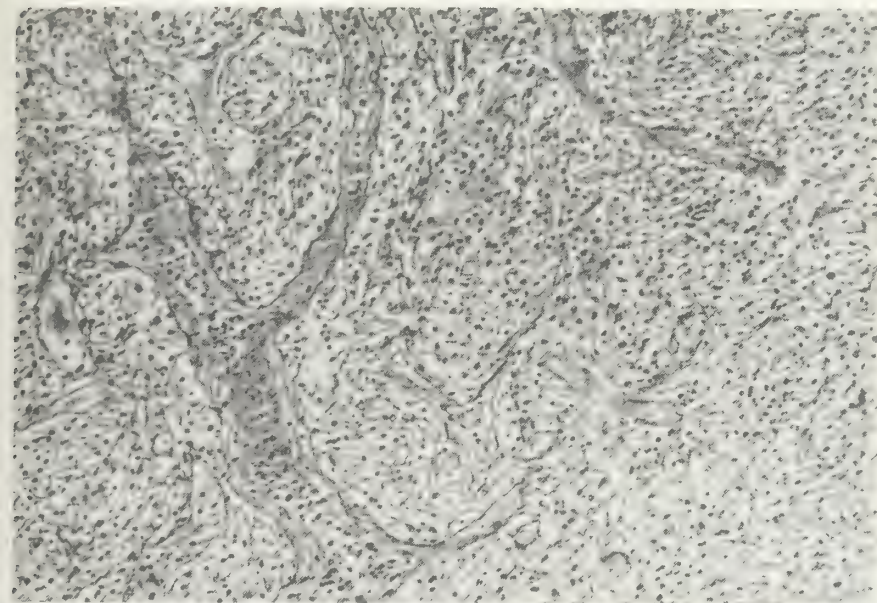


Figure 2

Proliferation of small arborizing vessels. (Hematoxylin and eosin; x150)

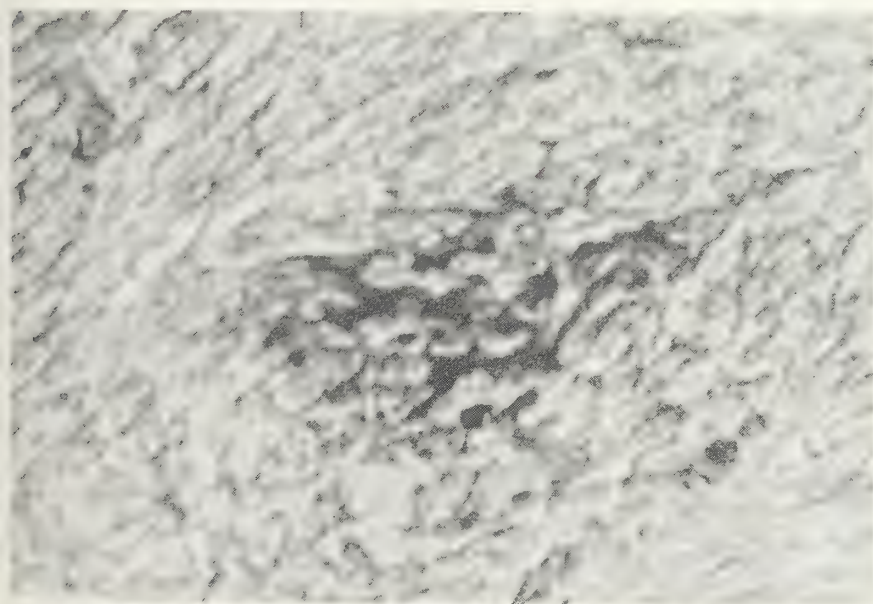


Figure 3

Interstitial PAS-positive intercellular material. (Periodic acid-Schiff; x250)

ANCEF[®]
brand of sterile
CEFAZOLIN SODIUM
GETS TO THE SITE



**OF SERIOUS
RESPIRATORY INFECTIONS**

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported:

Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocytopenia and positive direct and indirect Coombs tests have occurred.

Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported.

Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® ^{IV}/_{IM}
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company



Figure 1

Residual rachitic deformities in an adolescent.



Figure 2

N.B. showing rachitic changes.

INFANTILE RICKETS: A Report of Two Cases

HAROLD E. STADLER, M.D.
JERROLD R. SMITH, M.D.
Indianapolis

RICKETS IS A METABOLIC DISORDER in which poor bone mineralization results from a defect in calcium and phosphorus utilization. Insufficient vitamin D intake, or paucity of ultra-violet radiation to the skin, needed to change skin cholesterol to vitamin D, probably explains why the greatest incidence of rickets is in the spring and particularly in dark-skinned races.

Following absorption, vitamin D is carried to the liver, bound to plasma protein. Hydroxylation occurs at the 25 position (25 hydroxy vitamin D). The final active agent, 1, 25 hydroxy vitamin D, results from a further modification in the kidney.

It has been estimated that one microgram of 1, 25 dihydroxy vitamin D in daily supply is adequate for normal bone metabolism. For practical purposes, 400 IU of vitamin D is sufficient for infant or child. An inborn error in the synthesis of vitamin D (vitamin D dependency) increases the requirement substantially.

There is also evidence that the child receiving anticonvulsive therapy may require 800-1,000 IU of vitamin D daily. Routine administration of 1,000 IU of vitamin daily is to be discouraged since the first sign of toxicity may be a slowing in the growth of the subject. In the case of the child receiving anticonvulsants, the elevation of the alkaline phosphatase may suggest an impending problem.

It has been noted that the breast fed infant is more likely to develop rickets in the presence of vitamin D deficiency than the bottle fed infant.

Rickets is manifested radiologically by the failure of calcification in the metaphyses of long bones, which normally increase in length by the production and deposition of osteoid tissue. Rarefaction of the shaft of the bone also occurs with possible fracture, deformity or both (Figure 1).

Multiplication of the lowest normal levels of calcium and phosphorus of the serum ($9 \times 5 = 45$) has been used as a diagnostic and prognostic aid. At the level of 40, rickets is usually absent. A figure of 30 or less is indicative of active rickets. The alkaline phosphatase level is markedly elevated in rickets, and this factor has great value in determining rachitic activity.

N. B. was born Jan. 20, 1976, at term, and was breast fed. Allergic disease was rampant in the family, and the patient developed atopic eczema at the age of 6 weeks. She exhibited a moderate tibial torsion, and her progress was excellent; at 6 months of age she weighed 16 3/4 pounds, and at one year 21 1/4 pounds. She was given 10 drops of Vi-Daylin® daily, starting between 6-7 weeks.

Progression of the tibial torsion led to investigation (Figure 2). The serum calcium level was 7.4 mg.%, phosphorus 3.2 mg.% (product 29.7) and the phosphatase level 600 U, which is approximately six

From the Department of Pediatrics, Community Hospital, 1500 N. Ritter, Indianapolis 46219.
Acknowledgement: Photographs by Mr. Thomas G. Wager.

times the normal. Treatment was begun with vitamin D concentrate (3,000 IU daily), and within one month the changes by x-ray were minimal. The calcium serum level was found to be 10.4 mg.% phosphorus 5.2 mg.%, and the alkaline phosphatase 228 units. The vitamin D dosage was reduced to 800 IU daily.

D. L. was born Sept. 14, 1975. He was a full-term infant and was hospitalized at the age of 2 weeks because of a suspected septic state. He was troubled by nasal stuffiness, recurrent otitis media and milk intolerance. Eczema developed at the age of 6 months, bowleg and dental caries at 15 months. His diet had been excessively of vegetable origin. The serum calcium was 7.8 mg.%, the phosphorus 3.1 mg.%, and the phosphatase 1,080 U. Treatment

with vitamin D concentrate was begun and rapid healing noted (*Figure 3*).



Figure 3
(D.L.) Healing rickets with residual bowing.

It has become commonplace experience to have parents question the child's need for "a quart of milk per day." Compliance with recommended vitamin preparations is difficult to assess. The great increase in "milk allergy and milk tolerance" (lactase deficiency?) may

lead to severe calcium deficit since milk substitutes are expensive. Calcium supplements are mandatory in situations that require deletion of milk.

The rachitogenic nature of the excessive cereal diet should be noted. The phosphorus content is contained in inositol hexaphosphoric acid (phytic acid) compound. Not only is this compound relatively insoluble, but its combination with calcium in the gastrointestinal tract makes both elements equally unavailable for absorption. Should the predominantly cereal and vegetable diet be given during periods of active growth as in convalescence from chronic illness (malnutrition, hypothyroidism, prematurity), the period of the 6-18th month would represent the period of greatest risk for the development of rickets.



MALPRACTICE INSURANCE AVAILABLE

**Owned by
PHYSICIANS**

**Operated by
PHYSICIANS**

**For the protection of
PHYSICIANS**

P&S LI

Physicians & Surgeons Liability Insurance Co., Inc.
800 Mac Arthur Boulevard / Munster, Indiana 46321
219 836-2288

NICOTINE ADDICTION: Treatment with Medical Hypnosis

PART 1

HANUS J. GROSZ, M.D.
Indianapolis

WITH THE RECENTLY passed Indiana legislation prohibiting smoking in all public buildings and with the launching by the federal government of an intensive educational crusade against the smoking habit, more smokers may turn to their physicians for guidance and for treatment of their nicotine dependence.

In this first of a series of papers devoted to the medical uses of hypnosis, we report the results of a three month follow-up study of an unselected group of 543 self-referred and physician-referred cigarette smokers whose nicotine dependence was treated with one single session of individual hypnotherapy.

SUBJECTS

The subjects, all of whom came specifically for hypnosis treatment, are 422 Marion County patients and 121 patients from outside the county.

From the Institute of Psychiatric Research, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46223.

Acknowledgement: The assistance of Steve Bojrab, freshman medical student at I.U. School of Medicine, who helped in the follow-up study, and Phyllis Bramer, research assistant, is appreciated.

Sixty-four of the patients could not be reached for subsequent questioning. Of the 479 patients on whom we were able to obtain post-treatment information, 202, or 42.2%, were men and 277, or 57.8%, were women. The mean age of the men (range 15 to 78) was 41.6 and of the women (range 16 to 70), 39.9.

The men started smoking on the average when they were 17 years old and the women when they were 19. Both averaged between 30 and 35 cigarettes a day.

TREATMENT

The treatment was limited to a single 45 to 60 minute office session of individual hypnotherapy. Each session started with a review of the patient's smoking habits. Information was obtained about the patient's life style, both at home and at work; his moods and the stresses and situations which he associated in his mind with smoking; his general physical and mental health; and his reasons for wanting to stop smoking. After a brief review of the health and addictive hazards of smoking, time was also given to questions and answers about medical hypnosis, its uses, indications, limitations and dangers.

With the patient reclining in a comfortable arm chair, hypnosis was usually induced with progres-

sive relaxation or eye fixation techniques. Most patients attain satisfactory levels of hypnotic relaxation within 10 to 15 minutes.

After the induction of hypnosis, patients were given suggestions aimed at strengthening their determination not to smoke and their ability to maintain abstinence. They were given suggestions of aversion to the taste of smoking and were desensitized to internal and external stimuli triggering needs, urges and desires to light up a cigarette. Tense patients were taught how to relax and how to use autosuggestion. All patients were encouraged to call if they experienced any serious difficulties or distress.

RESULTS

A follow-up inquiry by telephone, at least three months after the treatment, was carried out by a medical student on a full-time summer fellowship. He was not otherwise involved in the project. We were able to reach and to obtain post-treatment results on 414, or 98.1%, of the locally residing patients and on 65, or 53.7%, of the non-local patients. The 479 patients thus provide three-month follow-up data on 88.2% of all the patients treated.

Success was defined as total abstinence from smoking for three months after treatment. Any resumption of smoking, even if to a

much reduced level, was defined as a treatment failure.

By this definition, 210, or 43.8%, of the subjects, were treated successfully and 269, or 56.2%, of the subjects were treated unsuccessfully. The success rate was the same for both men and women: 43.6% for the former and 44.0% for the latter.

There was no significant difference ($p=.452$) in the mean ages of the successfully and the unsuccessfully treated patients: 40.2 vs. 41.0 years of age. The age of onset of smoking did not play a significant role ($p=.213$) in determining success or failure.

DISCUSSION

Smoking is rapidly addictive and most smokers soon find themselves psychologically if not also physically dependent on nicotine. Dependence on cigarette smoking is brought on and reinforced not only by the chemical and physiological effects of nicotine but also by certain social aspects of the smoking situations, by the effects of smoking on the emotional state of the smoker and by the tension-reducing actions that compose the smoking behavior. They all act to reinforce the rewards obtained from smoking and weaken the will to abstain.

Abstinence from smoking is also made more difficult by the aversive, or negatively reinforcing, experience associated with nicotine withdrawal. The abstinence syndrome may include intense craving and such an obsessive preoccupation with smoking that it may absorb all the patient's waking thoughts and feelings; an annoying irritability and incontinence of temper that can place severe strain on all interpersonal relationships; insomnia with excessive daytime somnolence; tearfulness, depression or feelings of loss and deprivation reminiscent of mourning; light-headedness, in-

creased appetite and gain in weight; restlessness and impaired work performance.

By virtue of his qualifications, his skills, his authority and his special relationship to the patient, the physician is in the best position both to motivate the patient to quit smoking and to help him to withdraw from nicotine. A physical examination and three sessions of physician counseling have been reported to induce nearly half of heavy smokers to stop smoking.¹

Once the patient has stopped smoking, he may need the physician's support to cope with the after effects of nicotine withdrawal. High on the list is willingness by the physician to receive phone calls when the maintenance of abstinence is in serious jeopardy. In our experience, only a few patients make actual use of the opportunity to call if free to do so and few, if any, abuse it. The mere thought of being able to call if necessary is reassuring and helpful.

We have not resorted to prescribing medication but it may be temporarily beneficial. Meprobamate for use during the day or an antidepressant such as amitriptyline at bedtime may help to reduce tension and to combat depression and insomnia.

Hypnotherapy seems to hold out promise to success over a three-month period for nearly half of the patients seen in a single individual treatment session. Spiegel² reported similar results. However, his results with a single individual hypnotherapy session have been questioned because he obtained follow-up data on only 44% of the 615 smokers whom he had treated. In his study, 74% of those who resumed smoking did so within the first month.

Whether more than one session of hypnosis can substantially im-

prove the results obtained with one treatment needs to be seen. At least one study claims that success is positively correlated with the number of treatments.³ In our experience, further treatments have proven useful mainly in cases where relapses have occurred after a prolonged period of successful abstinence. It seems less effective if smoking is resumed within hours or a few days.

This study does not allow us to draw any conclusions about the long-range prospects for continued abstinence. No recovered nicotine addict is ever entirely free from the risk of re-addiction, and smoking only one cigarette, even after years of total abstinence, can trigger a resumption of compulsive smoking.

SUMMARY

This paper reports the results of a three-month follow-up study of 479 cigarette smokers whose nicotine addiction was treated with a single individual session of hypnotherapy.

The patients, who consist of 88.2% of the 543 subjects treated, were made up of 202 males and 277 females aged 15 to 78 years. They were smoking an average of more than 30 cigarettes a day.

Three months after a single treatment with hypnosis, 43% of the men and 44% of the women were still maintaining total abstinence from cigarette smoking.

REFERENCES

1. Rose, G, quoted in Editorial: Giving up smoking: How the various programs work. *Medical World News*, 53, Nov. 1, 1976.
2. Spiegel, H: A single-treatment method to stop smoking using ancillary self-hypnosis. *Internat. J. Clin. Exper. Hypnosis*, 18:235-250, 1970.
3. Orr, RG: Hypnosis helps reluctant smokers. *Practitioner*, 205:204-208, 1970.

PHEOCHROMOCYTOMA: Diagnosis and Management

J. HOWARD PRATT, M.D.
DAVID P. HENRY, M.D.
Indianapolis

A PHEOCHROMOCYTOMA may seem a mere medical curiosity rather than a real entity, since in the practice of medicine such a tumor appears so rarely. However, these tumors are not nonexistent, and when a patient with a pheochromocytoma goes unrecognized, he faces an outcome that is nearly certain to be fatal. The discussion that follows deals with diagnosis and management of the pheochromocytoma patient.

Pheochromocytomas have been found anywhere along the distribution of chromaffin tissue, which is laid down during fetal development and which has mostly disappeared by late childhood. The largest accumulations of chromaffin tissue are in the adrenal medulla and in the organ of Zuckerkandl at the origin of the inferior mesenteric artery. Most pheochromocytomas are located between the diaphragm and pelvic floor. In the sporadic, non-familial pheochromocytoma, about 80% of tumors involve a single adrenal, 10% are bilateral, 10% are extra-adrenal, and 10% are malignant. For this reason they are sometimes referred to as the "10% tumors."

The catecholamines norepinephrine (NE) and epinephrine (E) are synthesized from the precursor amino acid tyrosine. The enzyme phenylethylamine N-methyl trans-

ferase (PNMT) converts NE to E; this is almost exclusively a property of the adrenal medulla. (85% of adrenal catecholamine is epinephrine.) Even though most pheochromocytomas arise in the adrenal medulla, the majority of tumors secrete primarily NE. If, however, it is determined that there is predominate secretion of E, then the tumor is almost invariably located in the adrenal. A purely E secreting tumor is extremely uncommon and difficult to diagnose since hypertension is minimal; in fact, some patients may present with shock.

The variable complex of symptoms experienced by a patient with a pheochromocytoma probably reflects mostly the proportion of NE to E secreted. Symptoms stem more from secretion of E, while NE determines the level of hypertension. Nearly all patients have troublesome headaches, and almost as common is excessive sweating. Other symptoms are palpitations, episodes of uneasiness or anxiety, pallor, flushing, weakness, nausea, tremor, chest pain, shortness of breath, and abdominal cramps.

As is well known, any one patient's combination of symptoms occur in "spells," which may or may not appear related to precipitating events such as smoking, sexual intercourse, pressure on the abdomen, and defecation. Symptoms precipitated by micturition denote a urinary bladder location for the pheochromocytoma. Although the hypertension is famous for its paroxysmal nature, probably more than 50% of patients have sustained hypertension. An orthostatic de-

crease in blood pressure in an untreated hypertensive patient suggests the diagnosis of pheochromocytoma. (This finding is also suggestive of primary aldosteronism.) In some patients the single clue to the existence of a pheochromocytoma is a hypertensive crisis associated with either pregnancy, the administration of a general anesthetic, surgery or use of certain drugs. Such drugs as morphine, ACTH, parenteral guanethedine or parenteral methyl-dopa may release catecholamines from the tumor, while propranolol may increase the pressor response to circulating E.

The diagnosis of pheochromocytoma is made from biochemical tests that can be performed on an outpatient basis. There are basically three kinds of measurements that are made in urine: vanil mandelic acid (VMA), total metanephrines (normetanephrine and metanephrine), and *free* catecholamines. These tests provide very meaningful information and are available to any physician. They are nearly equal in their sensitivity and specificity; if all three are carried out simultaneously, one will detect 95% of pheochromocytomas. The urine must be kept acidic by prior addition of HCL or acetic acid to the collection container.

There are, however, a few cautions that need mention. VMA screening tests, simple "kit" type assays, nonspecifically quantitate phenolic acids. It is with these tests that the eating of bananas, drinking coffee and the like can falsely elevate the VMA. The excretion of *total* catecholamines (sulfate and

From the Specialized Center of Research (SCOR) in Hypertension, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

glucuronide conjugates) is easily affected by dietary catecholamines, and as a test is sufficiently insensitive to the magnitude of catecholamine secretion to justify its use.

Urinary excretion data can provide information about tumor size. If large amounts of VMA or metanephrines are secreted, the tumor is generally large, whereas smaller tumors secrete mostly catecholamines. In patients with intermittent hypertension, the collection of the urine for two to four hours after a symptomatic episode is a very useful procedure.

There is frequently the question of which blood pressure medicine interferes with which biochemical test. The most important of these to remember is that methyl-dopa elevates the excretion of urinary catecholamines (since methyl-dopa is a catecholamine). VMA excretion can be slightly lowered by methyl-dopa as well as clofibrate and monoamine oxidase inhibitors.

Other antihypertensive drugs such as reserpine, propranolol, and guanethidine will not interfere with most of the biochemical tests, but may slightly lower the urinary excretion of catecholamines and their metabolites through their inhibitory action on the sympathetic nervous system. To be completely safe, one can limit treatment to diuretics and hydralazine during the urinary collection period. Not unexpectedly, bronchodilators and nose drops can elevate urinary catecholamine excretion since they are chemically related to NE and E.

The quantitation of catecholamines in plasma was previously carried out by fluorometric methods, procedures that require meticulous technique and large plasma samples, and that frequently provided inaccurate results. A major advancement in this area was the development of the radioenzymatic as-

say for measurement of catecholamines. To carry out this assay, plasma is incubated with an enzyme which transfers a ^3H containing methyl group from S-adenosylmethionine (SAM) to the catecholamine and then the radiolabeled catecholamine is isolated and the radioactivity counted. The radioenzymatic assay used at Indiana University School of Medicine (developed by D. P. Henry) utilizes the enzyme PNMT to transfer a ^3H -methyl group from SAM to NE to produce ^3H -E. Employing this assay at this institution, measurements of plasma NE, as well as the urinary excretion of NE, including excretion measured in an easily collected morning urine sample ("sleep NE"), have clearly delineated patients with pheochromocytoma from other hypertensive patients. The measurement of NE can be made in plasma samples from multiple sites of venous drainage to find a tumor whose location has been elusive.

The radioenzymatic assay is making an important impact in investigative studies of the sympatho-adrenal system, and it appears that it may in part revise our approach to the diagnosis of pheochromocytoma. Similar assays are under evaluation for important metabolites of catecholamines in plasma, which may further increase our diagnostic accuracy.

To test for the presence of a pheochromocytoma one can administer either histamine, glucagon or tyramine since in most instances these substances will induce a pressor response in the pheochromocytoma patient. Since there is a very real danger in stimulating (by whatever means) the hypertension caused by a pheochromocytoma, and because of the availability of reliable biochemical tests, it is our opinion that provocative maneuvers should be virtually abandoned. Al-

though probably less dangerous, the hypotensive response to phentolamine, an adrenergic blocking agent, has not in general proven diagnostically helpful.

When the diagnosis of pheochromocytoma is firmly established, it has been our policy to try to find its location. Occasionally an intravenous pyelogram will show the tumor, and in our experience computerized tomography can delineate most adrenal pheochromocytomas. However, standard practice for us is to locate the tumor by arteriography. Knowing where the tumor resides and the anatomy of its blood supply allows the surgeon to better plan his approach. Also, it might be said that it is no small comfort for the diagnostician to *see* the tumor, to know it is really there.

Is arteriography dangerous? Not when carried out by an experienced radiologist and when patients are pre-treated with phenoxybenzamine (DibenzylinTM), an alpha adrenergic receptor blocking drug that has contributed greatly to the management of the pheochromocytoma patient. The dosage of phenoxybenzamine is determined by the antihypertensive response, and treatment should continue for a period of at least one week before adequate receptor blockade is achieved. Total protection against spikes in blood pressure is not attainable; during arteriography and surgery, preparations should be made for the administration of intravenous phenoxybenzamine (and propranolol if problematic tachycardia or arrhythmias occur). Use of propranolol should be limited to situations where alpha blockade has already been established.

It is not the intention of this discussion to describe approaches to the surgical excision of the tumors, but there are several aspects to the surgery that are important to emphasize:

• A team approach is required within the operating room, consisting of internist as well as surgeon and anesthesiologist.

• Pre-operative treatment with phenoxybenzamine dampens or may even abolish the hypertensive episodes that can be associated primarily with induction of anesthesia and with handling of the tumor.

• The adrenergic blockade created by phenoxybenzamine relieves the vasoconstrictor state produced by the excessive secretion of catecholamines and provides time prior to surgery for expansion of the vascular space.

Thus, the profound hypotension that may immediately follow removal of the pheochromocytoma is for the most part prevented.

The management of the pheochromocytoma patient from the

stage of tumor localization through to where surgery is carried out is no simple matter. It is our strong recommendation that these procedures be performed in hospitals where several such cases are handled annually.

Finally, a word about familial pheochromocytomas since their characteristics differ in some ways from the more common sporadic type. Fifty per cent of familial tumors are bilateral, yet, extra-adrenal locations almost never occur. The familial pheochromocytoma is more likely to secrete epinephrine, and in some instances this may be the only biochemical abnormality, which can make it difficult to diagnose. These tumors usually occur as part of well recognized syndromes.

Multiple endocrine adenomatosis,

type II (MEA-II) or Sipple's syndrome consists of pheochromocytoma, medullary thyroid carcinoma and primary hyperparathyroidism. Pheochromocytoma is not associated with MEA-I (pituitary, pancreatic and parathyroid tumors); only hyperparathyroidism is common to MEA I and II. A small percentage of patients with von Recklinghausen's neurofibromatosis and von Hippel-Lindau's cerebellar hemangioblastomatosis will have pheochromocytomas.

In summary, routine biochemical tests can detect the presence of most pheochromocytomas. Once the diagnosis is established, subsequent interventions (localization and surgery) are best carried out by an experienced medical team and after achieving adrenergic blockade with phenoxybenzamine.

Spend thirty minutes with us. You may never buy a car again.

Before you buy, you owe it to yourself to talk with Dave Waite Leasing. We've built our reputation on making leasing easy to understand. And easy to afford.

Leasing a car is not reserved for businessmen. Leasing is for anyone who wants to hold their transportation expenses to a minimum.

And for many people, leasing offers advantages not available when buying. There is no down payment necessary when you lease. There are possible savings on insurance costs. The interest rate to lease runs lower than the rate to buy. And Dave Waite will lease you any car or truck sold in America today.

If you're planning to purchase a new car soon, wait until you spend 30 minutes with us.

The more you know, the more you'll agree: Dave Waite Leasing is The Intelligent Alternative to buying your next car.

Visit or call your nearest Dave Waite Leasing location.

The Dave Waite Leasing Program has been officially endorsed for the membership of the Indiana Dental Association, The Indiana Grain & Feed Association, Inc., the Home Builders Association of Indiana and the Indiana State Bar Association.



Dave Waite Leasing

**Indianapolis (4 locations) • Anderson/Muncie
Lafayette • Bloomington**

PSYCHOTHERAPY:

What Is It?

DAVID F. WEHLAGE, M.D.
South Bend

PHYSICIANS KNOW the term *psychotherapy* and refer patients for psychotherapy, but very few physicians know what it really is and what their patients experience when treated with psychotherapy. This paper will describe what psychotherapy is, who can benefit from it, and what is accomplished through it.

DEFINITION

Psychotherapy is the communication of person-related understanding, respect, and a wish to be of help. Psychotherapy occurs anytime one person sends a message to a responsive person

- whose personal feelings, thoughts and actions he is truly curious in knowing,
- whose individuality he respects, and
- whose state of well-being is of concern to him.

Psychotherapy can be defined as a special case of "whatever it is" that any two or more humans attempt to establish between themselves whenever they seek to obtain from or give something to each other. In psychotherapy, the seeking of one (the patient) and the giving of the other (the psychotherapist) become exaggerated. In communicating a state of discomfort, the patient brings to the rela-

tionship a set of expectations that are based on what he has known in the past about people who help; this is called *transference* (preconceptions). The therapist brings some special knowledge and skill in sending the message of understanding and respect and a wish to help.

Psychotherapy involves a *curiosity* of both patient and therapist to get to know the patient and his "story" as completely as possible. Psychotherapy is the development of an alliance between two people, which means the ability of two people to recognize the individuality and separateness of each while getting to know each other. The patient must be able to give up or resolve his transference.

Thus, psychotherapy is really a process of eliciting a detailed personal history. How to investigate the patient's life in a helpful manner is the skill possessed by the psychotherapist.

Psychotherapy is a collaborative process of helping the patient help himself and helping him find out what *he* wants, not what the therapist or other people want for him. There is nothing coercive or involuntary about psychotherapy.

In brief psychotherapy (1-6 months), the orientation is to help the patient answer the question, "What can I do to solve and prevent problems?"

The author, an associate professor of psychiatry at Indiana University School of Medicine, maintains a private practice at 634 N. Lafayette Blvd., South Bend, Ind. 46601.

In long-term psychotherapy (1-2 years), the question, "What did I do to cause the problem?" is explored and answered.

From what has been said, psychotherapy is a self-help process, whereas counseling techniques involve *telling* the patient what to do.

Because the psychotherapist believes the patient can make sense out of his life and find his own answers, psychotherapy is ultimately more rewarding and growth-oriented than counseling. Many people look to the psychotherapist for the answers and become frustrated early in therapy when they are expected to work to find their own answers.

One patient has said, "I came to therapy hoping to receive butter for the bread of life. Instead, at the end, I emerged with a pail of sour milk, a churn, and instructions on how to use them."

Psychotherapy is a pilgrimage in gaining self-awareness. The therapist has been the pilgrimage before, but not the particular pilgrimage with each particular patient in therapy. He guides the patient and is a companion for the patient, but he does not create the patient's experiences.

Psychotherapy involves a search for personal change. The things that must be understood about the nature of personal change are:

- It involves the active participation of the changed based upon the supposition he wants to change.

- It takes place in the context of a trusting relationship or companionship.

- The threat of change leads to emotional turmoil, which means the patient often gets worse before he gets better.

- Change proceeds best if there are some achievable goals and some signs of progressive relief which psychotherapy offers.

DISCUSSION

Each person has his own story to tell—his own life. *The patient must tell his story to understand himself.* Through his own insight, he can then change. There must be someone to care about his tale. The process of telling his story is more important generally than what he tells. What is dealt with in treatment is only what the patient is *able* and *willing* to bring into focus, what he is able to make comprehensible and discussable; in other words, what he can stand talking about and having the therapist talk about. Psychotherapy is basically a learning process of helping the patient express things directly since he has probably only been able to express things indirectly. It is obvious that most of the patient's emotional troubles would not be so troubling to him if he could face them in an open manner.

In determining who might benefit from psychotherapy, the referring physician needs to be aware of the following important questions.

- Is the patient motivated by discomfort to change?

- Is his behavior self-defeating to him?

- Does he feel somewhat to blame for his difficulty?

- Can he communicate his feelings verbally since psychotherapy is a talking process?

- Is he willing to look for personal change and to collaborate with the psychotherapist?

- Is he free of serious social problems that may require counseling initially?

Another way to graphically separate those who might benefit from psychotherapy from those who will not likely benefit is to realize there are *Garlic* people and *Onion* people.

The Garlic person says, "I have no problem and I do not need help." He bothers everyone else with his maladaptive responses but is not personally bothered or uncomfortable with himself. He will not benefit from a talking kind of therapy.

The Onion person says, "I have a problem, I feel unhappy, and I need help." He feels as distressed about himself as others feel distressed for him. The Onion person is a prime candidate for psychotherapy since he fits the criteria listed above.

A psychotherapist *cannot* make someone stop certain behaviors unless the person wants to stop them. The words of the psychotherapist have no more influence than anyone else's words unless the person allows himself to be responsive to the words of the therapist and is actively looking to change himself. For instance, a psychotherapist *cannot* make someone stop drinking or make someone stop sexual affairs unless the individual himself wants to stop the behavior and find other ways to express his feelings.

The factors or psychological maneuvers a psychotherapist is trained to use that account for the success of psychotherapy are difficult to define, but five have been differentiated. These are used in various combinations by every psychotherapist.

- Suggestion—presenting alternatives or views for the patient to consider.

- Abreaction—encouraging the release of emotion in the session.

- Persuasion—using the patient's own motivations for a different purpose.

- Clarification—simplifying the patient's self-generated complexities through explanation.

- Interpretation — presenting what appear to be hidden meanings

and motivations in the patient's attitudes and behaviors.

Psychoanalysis is a special form of psychotherapy that very few therapists use. Most psychotherapists sit face-to-face with their patients in comfortable chairs in a comfortable setting. The use of a couch with the patient lying down is very rare. Most psychotherapists have worked to resolve their own emotional conflicts, so most have personal experience with what a self-reflective emotional process can do. Most psychotherapists are students of their own emotional lives, as well as being students of the emotional lives of patients. Psychiatrists, clinical psychologists, and psychiatric social workers have all been trained in psychotherapy.

RESULTS

Through psychotherapy, the patient comes to learn some of the following facts about life:

The world is not so bad, and people are more trustworthy than expected. No one is any stronger or any weaker than anyone else. There are no great men since all men have a basis of equality.

One has to be less demanding on people and give up some things he always wanted and thought he needed to live. Getting everything one wants never leads to contentment.

If one achieves something or gets pleasure out of something, one's own satisfaction must be enough. The most important things each man must do for himself. Disciplining oneself in carrying out a self-chosen duty is necessary for self-esteem.

One must learn to delay gratification. One must not only learn to wait for what he wants but learn to take something as a substitute.

Separations or losses are painful and sad but need not be cata-

strophic. The gratification of interpersonal closeness need not be physical (sexual), but can be symbolic. Life is a series of endings. No experience remains the same forever.

If one wants to reach a goal, one has to institute realistic action. Sitting back and wishing is not likely to produce results. There is a difference between action and motion. All important decisions must be made on the basis of insufficient data.

Tension, suffering, anxiety, depression are not as bad as the person thought them to be, and he may discover strength he never knew he had. Mere avoidance behavior is not likely to be effective.

Certain interpersonal maneuvers do not work and are self-defeating. Examples include finding out that keeping anger to one's self is not helpful and letting it out need not be destructive. Feeling revengeful or feeling cheated seldom lead to fulfillment.

Cooperation as a technique for getting along with others generally brings the greatest returns. One cannot "buy" others but one can cooperate. Other people are not obligated to cooperate nor are efforts to subjugate them likely to pay off. It is wise to avoid other persons whose exploitive tendencies have been identified.

Honesty about one's feelings and motives is a good policy even though they may be unpleasant. This does not mean that one needs to broadcast less desirable tendencies. Recognition of their existence is no justification for acting on them. In the end, one is judged by his actions and not his fantasies. One is responsible for his actions and cannot blame someone else. It is most important for every person to run out of scapegoats.

One needs to respect, accept, and

subordinate oneself to higher authority. Accepting authority does not entail abandoning one's freedom. On the contrary, accepting authority frees one from struggles with others.

It is crucial to recognize the past is irreversible, and that, "This is it!"

Each of us is ultimately alone, and the secret of life is that there is no secret.

BIBLIOGRAPHY

1. Weiner, M: "Self-Exposure by the therapist as a therapeutic technique," *Amer. J. Psychotherapy*.
2. Melges, F: "Future Oriented Psychotherapy," *Amer. J. Psychotherapy*.
3. Strupp, H: "Specific vs. nonspecific factors in psychotherapy and the problem of control," *Arch. Gen. Psych.*, 23:393-401, November 1970.
4. Sifneos, P: "Two different kinds of psychotherapy of short duration," *Amer. J. Psych.*, 123:1069-1074, March 9, 1967.
5. DeWald, P: "The termination of psychotherapy," *Psychiatry Digest*, pp. 33-46, October 1967.
6. Chessick, R: "Empathy and love in psychotherapy," *Amer. J. Psychotherapy*, 19:205-219, April 1965.
7. Tarachow, S: *Introduction to psychotherapy*, International Universities Press, New York, 1963.
8. Abrams, G: "Persuasion in psychotherapy," *Amer. J. Psych.*, 124:97-105, March 9, 1968.
9. Chessick, R: *How psychotherapy heals*, Jason Aronson Co., New York, 1972.
10. Strupp, H: "Toward a specification of teaching and learning in psychotherapy," *Arch. Gen. Psych.*, 21:203-212, August 1969.
11. Coleman, J: "Aims and conduct of psychotherapy," *Arch. Gen. Psych.*, 18:1-6, January 1968.
12. Reisman, J: "The definition of psychotherapy," *Mental Hygiene*, 55: 413-417, July 1971.
13. Fabrikant, B, et al: *To Enjoy is to Live*, Nelson-Hall, Chicago, 1977.
14. Kuehn, JL: "Who can use psychiatry," *The Journal of the Indiana State Medical Association*, 59:1298-1300, 1966.
15. Kopp, SB: *If you meet the Buddha on the road, kill him!* Science and Behavior Books, Inc., 1972.

Practical Management of Diabetes . . .

CONTINUED FROM PAGES 1063-1067

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.**

ANSWER THE FOLLOWING:

Answer—a) if 1, 2, 3 only are correct
b) if 1 and 3 only are correct
c) if 2 and 4 only are correct
d) if 4 only is correct
e) if all are correct

1. In attempting to determine if a patient has diabetes:
 - 1) the two hour postprandial glucose is the most sensitive.
 - 2) the fasting glucose is the most useful in determining the necessity for treatment.
 - 3) patients with mild abnormalities of either fasting or postprandial blood sugars frequently never develop clinical diabetes.
 - 4) the glucose tolerance test should be routinely performed if you suspect diabetes.
 - a)
 - b)
 - c)
 - d)
 - e)
2. If a patient has a fasting blood sugar of 150 mg% during an acute illness:
 - 1) he has a statistically increased risk for developing vascular disease.
 - 2) he will invariably develop clinical diabetes within the next 10 years.
 - 3) he is much more likely to develop diabetes if he is obese.
 - 4) a glucose tolerance test should be performed.
 - a)
 - b)
 - c)
 - d)
 - e)
3. When treating the obese, adult onset diabetic with diet:
 - 1) caloric restriction is more important than carbohydrate restriction.
 - 2) modest caloric restriction with weight loss of 3-4 pounds per month is frequently more effective than more severe caloric restriction.
 - 3) diets high in carbohydrate and low in fats and total calories may be effective in lowering both blood sugar and serum triglycerides.
- 4) weight loss alone without changes in carbohydrate content will improve blood sugar control.
 - a)
 - b)
 - c)
 - d)
 - e)
4. Maintenance of blood sugars near normal in diabetic patients can be expected to reduce the incidence of or delay the onset of:
 - 1) diabetic symptoms.
 - 2) diabetic neuropathy.
 - 3) diabetic cataracts.
 - 4) heart attacks.
 - a)
 - b)
 - c)
 - d)
 - e)
5. In the adult, diabetes mellitus is associated with an increased risk of cardiovascular disease in:
 - 1) Americans and Western Europeans.
 - 2) all countries and ethnic groups studied.
 - 3) women much more so than in men.
 - 4) poorly treated patients only.
 - a)
 - b)
 - c)
 - d)
 - e)
5. In the adult, diabetes mellitus is associated with an increased risk of cardiovascular disease in:
 - 1) Americans and Western Europeans.
 - 2) all countries and ethnic groups studied.
 - 3) women much more so than in men.
 - 4) poorly treated patients only.
 - a)
 - b)
 - c)
 - d)
 - e)
6. Oral agents in the treatment of diabetes:
 - a) are safer than insulin in the elderly patient with renal or hepatic disease.
 - b) lower the incidence of cardiovascular disease.
 - c) are usually effective in normalizing blood sugar even in the patient with poor dietary adherence.
 - d) usually can be avoided when there is good dietary adherence.
 - e) are useful in patients on insulin to smooth out their sugar control.

BEST POSSIBLE ANSWER. ONE ANSWER ONLY:

6. Oral agents in the treatment of diabetes:
 - a) are safer than insulin in the elderly patient with renal or hepatic disease.
 - b) lower the incidence of cardiovascular disease.
 - c) are usually effective in normalizing blood sugar even in the patient with poor dietary adherence.
 - d) usually can be avoided when there is good dietary adherence.
 - e) are useful in patients on insulin to smooth out their sugar control.

CME QUIZ

7. Diabetic retinopathy:
 - a) occurs more commonly in patients with fasting blood sugars 200 mg% or greater.
 - b) has no effective treatment.
 - c) requires specialized equipment and expertise for its detection.
 - d) rarely occurs in patients over 50.
 - e) all of the above.
8. The juvenile diabetic patient:
 - a) usually requires initial specialized care and education.
 - b) should ideally be cared for by a family practitioner/specialist team.
 - c) usually benefits from a diabetes camp experience.
 - d) should not receive oral hypoglycemic agents.
 - e) all of the above.

9. Regarding the relationship between control of blood sugar and the development of complications, which of the following statements is **not** true:
 - a) The level of blood sugar control during the first five years of diabetes bears the most significant relationship to the subsequent development of retinopathy.
 - b) In experimental animals, good blood sugar control prevents or reverses diabetic renal lesions.
 - c) In studies of diabetic neuropathy in man and experimental animals, good blood sugar control improves nerve conduction.
 - d) Patients who have survived forty or more years of diabetes usually are severely disabled by diabetic complications.
 - e) There is no evidence that control of blood sugar will decrease the incidence of heart attacks in adult onset diabetes.

The following are answers to the CME quiz that appeared in the August 1978 issue of The Journal. The article upon which the questions are based was "Current Concepts in the Management of Pulmonary Tuberculosis," by Richard Ziegler, M.D., Stephen J. Jay, M.D., and Richard E. Brashear, M.D.

- | | |
|------|------|
| 1. b | 4. c |
| 2. e | 5. b |
| 3. d | 6. d |

10. In terms of morbidity, the single most preventable complication of diabetes mellitus is:
 - a) heart attacks.
 - b) peripheral vascular disease.
 - c) foot lesions.
 - d) strokes.
 - e) congestive heart failure.

The following are answers to the Sandoz Prize Article CME quiz that appeared in the August 1978 issue of The Journal. The article upon which the questions were based was "Hemorrhagic Diatheses: Diagnosis and Management," by Ahmad Sami Ahmadzai, M.D.

- | | |
|------|------|
| 1. c | 4. b |
| 2. c | 5. c |
| 3. a | 6. e |

11. Each return visit by a juvenile diabetic should include all of the following **except**:
 - a) a careful history.
 - b) a fundoscopic and visual acuity examination.
 - c) a serum creatinine or BUN.
 - d) a urinalysis.
 - e) a blood sugar.

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer sheet for Quiz: (Diabetes . . .)

- | | |
|------------------|-------------------|
| 1. a, b, c, d, e | 7. a, b, c, d, e |
| 2. a, b, c, d, e | 8. a, b, c, d, e |
| 3. a, b, c, d, e | 9. a, b, c, d, e |
| 4. a, b, c, d, e | 10. a, b, c, d, e |
| 5. a, b, c, d, e | 11. a, b, c, d, e |
| 6. a, b, c, d, e | |

Name (please print or type) _____

Address _____

Identification number (found above your name on mailing label) _____

Signature _____

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of THE JOURNAL for my information.

To be eligible for credit for this month's quiz, send your completed, signed application before January 15, 1979, to: Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.

Indiana University CME Courses

Dec. 6: Office Orthopedics (Indianapolis);

Dec. 13-14: Asthmas and Related Diseases (Indianapolis);

Jan. 15-17: Cross-Sectional Echocardiography Workshop (Indianapolis);

Feb. 7-8: Coronary Artery Disease (Indianapolis);

Feb. 15: Medical Emergencies (Richmond).

For information, write or call the Indiana University School of Medicine, Division of Postgraduate Medical Education, 1100 W. Michigan St., Indianapolis 46202. Tel: (317) 264-8353.

University of Texas CME Course

"Radiology of the Acutely Ill and Injured Patient" will be presented Jan. 26-27 in Houston by the Department of Radiology and the Health Science Center of the University of Texas Medical School. The course meets the criteria for 14 credit hours in Category 1 of the AMA's Physician's Recognition Award.

Contact the Division of Continuing Education, University of Texas Health Science Center at Houston, P.O. Box 20367, Houston, Tex. 77025.

One-Day Cincinnati Seminar

"Psychiatry and the Law—Defense of Not Guilty by Reason of Insanity" will be presented Saturday, Nov. 11, at The Christ Hospital in Cincinnati by the hospital Psychiatric Department. The course offers eight Category 1 credit hours. Participants are nationally known and are representative of forensic medicine, forensic psychiatry and the legal profession.

Contact Mrs. June Hosick, Director of Educational Services, The Christ Hospital, Tel: (513) 369-2300, or Glenn W. Weaver, Director of Psychiatry, The Christ Hospital, Tel: (513) 961-4355.

Pediatric Dermatology Seminar

The sixth annual Pediatric Dermatology Seminar will be held in Darwin's Galapagos Islands, Feb. 17-25, aboard the M/V Buccaneer, a luxury ship. Daily lectures and discussions will be led by Dr. Guinter Kahn of Miami Beach.

For more information about the seminar, contact Dr. Kahn at 16800 N.W. 2nd Ave., No. Miami Beach, Fla. 33169.

New York CME Programs

The Network for Continuing Medical Education (15 Columbus Circle, New York City 10023) has announced the following programs:

Nov. 27-Dec. 10: "Cardiac Auscultation." Four-part telecourse cosponsored by Georgetown University School of Medicine, acceptable for Category 1 credit by the AMA and by the American Academy of Family Physicians for prescribed credit.

Dec. 11-24: "Chest Radiographs: Normal and Its Variations and Pleural Fluid."

Dec. 11-24: "Penetrating Wounds of the Abdomen: When to Operate."

Michigan CME Offerings

The following courses are sponsored by the University of Michigan Medical School and meet criteria for Category 1 credit. For further information, contact the university's Department of Postgraduate Medicine and Health Professions Education, The Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48109.

Jan. 18-20: Rheumatology, for rheumatologists, internists and family physicians;

Feb. 4-9: Family Practice Update, for family physicians;

Feb. 15: Continuing Pathology, for pathologists;

Feb. 19-23: Emergency Medicine, for family physicians, internists and emergency physicians;

Feb. 27-28: Topics in Psychosomatic and Behavioral Medicine, for psychiatrists and primary care physicians.

Symposium on Malnutrition

The Methodist Hospital of Indianapolis will conduct a symposium entitled "Diagnosis and Treatment of Malnutrition" on Nov. 15 in Wile Hall, immediately adjacent to the hospital. Registration fee is \$25. The program is approved for eight hours credit by the AMA and eight hours elective credit by the AAFP.

Kentucky CME Courses

Nov. 16-18: "Cancer and Medicine 1978," 13 hours credit;

Dec. 1-2: "Fiberoptic Bronchoscopy: A Workshop," 13 hours credit.

For information, contact Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington 40506. Tel: (606) 233-5161.

NEW increased limits under ISMA sponsored income protection plan

33 $\frac{1}{3}$ % more in fact! You can now provide yourself monthly income disability protection up to \$2,000 from the previous limit of \$1,500 (subject to a participation of \$3,500 per month with other companies) if you are disabled and unable to work due to an accident or illness.

OTHER INSURANCE PLANS AVAILABLE

In addition to this disability income protection that now helps you replace more of your earned income when you cannot work, there are four other Association sponsored supplemental insurance plans. You, as an ISMA member physician or professional corporation are eligible to add to your protection through these supplemental plans.

- **EXCESS MAJOR MEDICAL PLAN** provides coverage after your present plan is exhausted. Up to \$250,000 coverage and two deductibles available (\$15,000 or \$25,000). Unlimited surgical schedule and includes extended care and nursing home benefit.
- **OVERHEAD EXPENSE PLAN** provides needed dollars to help you pay off overhead expenses (employees' salaries, rent, utilities, property taxes, etc.) in the event of your disability. When disability strikes—your business overhead expenses keep right on going—even when you can't.
- **FAMILY LIFE INSURANCE PLAN** provides benefits up to \$60,000 in the event of your death.

ALL PLANS ARE ALSO AVAILABLE FOR PROFESSIONAL CORPORATIONS

COUPON

For information on the ISMA sponsored

- | | | |
|--|---|---|
| <input type="checkbox"/> Income Protection Plan | <input type="checkbox"/> Overhead Expense Plan | <input type="checkbox"/> Professional Corporation |
| <input type="checkbox"/> Excess Major Medical Plan | <input type="checkbox"/> Family Life Insurance Plan | |

Administered by

Dr. _____
Street _____
City _____ Zip _____



Mail to:
Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

j. russell townsend and associates

Immunoblastic Lymphadenopathy

CONTINUED FROM PAGE 1069

composed of monomorphic cellular infiltrate in contrast to polymorphic cellular infiltrate seen in immunoblastic lymphadenopathy.

The distinct clinical features of the disorder are generalized lymphadenopathy, hepatosplenomegaly, and serologic evidence of an immunologic abnormality such as a polyclonal gammopathy and Coomb's positive hemolytic anemia. The clinical course is described as frequently stormy, with severe infection leading to death. Spontaneous remission did occur in some patients even without therapy.

Because of the lack of uniform

response to presently available therapy, it is probably wise not to consider chemotherapy, which may enhance the patient's susceptibility to infection. Spector and Miller⁸ suggest that corticosteroids alone be used in the initial therapeutic trial, and to consider cytotoxic therapy when progression occurs.

REFERENCES

1. Lukes RJ, Tindle BH: Immunoblastic lymphadenopathy. *New Engl J of Med* 292:1-8, 1975.
2. Frizzera G, Moran EM, Rappaport H: Angioimmunoblastic lymphadenopathy. *Am J of Med* 59:803-818, 1975.
3. Rappaport H, Moran EM: Angio im-

munoblastic lymphadenopathy. *New Engl J Med* 292:42-43, 1975.

4. Kessler E: Angio-immunoblastic lymphadenopathy: A case study. *Cancer* 38:1587-1590, 1976.
5. Moore SB, Harrison EG, Weiland LH: Angioimmunoblastic lymphadenopathy. *Mayo Clin Proc* 51:273-280, 1976.
6. Schultz DR, Yunis A: Immunoblastic lymphadenopathy with mixed cryoglobulinemia. *New Engl J Med* 292:8-12, 1975.
7. Palutke M, Khilani P, Weise R: Immunologic and electronmicroscopic characteristics of a case of immunoblastic lymphadenopathy. *Am J Clin Pathol* 65:929-941, 1976.
8. Spector JJ, Miller: Immunoblastic lymphadenopathy. *JAMA* 238:1263-1265, 1977.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Required by 39 U.S.C. 3685)

1. Title of Publication: THE JOURNAL of the Indiana State Medical Association. 1A. Publication No. 284440.

2. Date of Filing: Sept. 30, 1977.

3. Frequency of Issue: Monthly

3A. No. of Issues Published Annually: 12.

3B. Annual Subscription Price: \$14.00.

4. Location of known office of publication (Street, City, County, State and ZIP Code (Not printers) 3935 N. Meridian St., Indianapolis, Marion, Indiana 46208.

5. Location of the headquarters or general business offices of the publishers (Not printers): 3935 N. Meridian St., Indianapolis, Indiana 46208.

6. Names and complete addresses of publisher, editor, and managing editor: Publisher (Name and Address): Indiana State Medical Association, 3925 N. Meridian St., Indianapolis, IN 46208; Editor (Name and Address): Frank B. Ramsey, M.D., 3935 N. Meridian St., Indianapolis, IN 46208; Managing Editor (Name and Address): Martin T. Badger, 3935 N. Meridian St., Indianapolis, IN 46208.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): Name and Address: Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, IN 46208. Non-profit corporation, no stockholders.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, PSM). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes (Check one): Have not changed during the preceding 12 months.

10. Extent and nature of circulation:

	Average No. copies each issue during preceding 12 months	Actual No. copies of single issue published nearest to filing date:
A. Total No. copies printed (Net Press Run)	5,400	5,300
B. Paid circulation		
1. Sales through dealers and carriers, street vendors and counter sales	0	0
2. Mail subscriptions	5,039	4,957
C. Total paid circulation (Sum of 10B1 and 10B2)	5,039	4,957
D. Free distribution by mail, carrier or other means, samples, complimentary and other free copies	280	287
E. Total distribution (Sum of C and D)	5,319	5,244
F. Copies not distributed:		
1. Office use, left over, unaccounted, spoiled after printing	81	56
2. Returns from news agents	None	None
G. Total (Sum of E, F1 and 2—should equal net press run shown A)	5,400	5,300

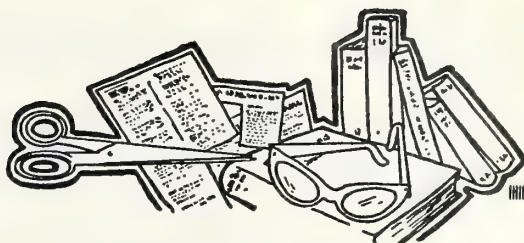
11. I certify that the statements made by me above are correct and complete. Signature and title of editor, publisher, business manager, or owner: Donald F. Foy, Business Manager.

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual) 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in item 1 at the phased postage rates presently authorized by 39 U.S.C. 3626.

Signature and title of editor, publisher, business manager, or owner: Donald F. Foy, Business Manager.

BOOK REVIEWS



The Metabolic Management of the Critically Ill

Douglas W. Wilmore, M.D., Plenum Publishing Corp., 227 W. 17th St., New York, N.Y. 10011. Copyright 1977. 262 pages plus Support Plan and Pad of Metabolic and Nutritional Work Sheets. \$22.50. (Dr. Wilmore is with the U.S. Army Institute of Surgical Research, Brooke Army Medical Center, Ft. Sam Houston, Tex.)

The book is so organized as to answer specific questions concerning the metabolic and nutritional problems of critically ill patients. Its five chapters cover energy balance, control of body temperature, hormonal control of body fuels, alterations in intermediary metabolism, and feeding the patient.

An appendix supplies a metabolic support plan. A supplemental booklet is provided for this topic, as is a pad of nutritional and metabolic worksheets. The text is simply written and well illustrated, with tables, charts, and line

drawings.

This is essentially a handbook, in the best sense of the word. It can be recommended for all physicians and other health practitioners charged with the care of critically ill patients. The several chapters are presented in the table of contents under headings in the form of questions that are both provocative and pertinent. Examples: What is Thermal Balance? How is Heat Lost From the Body? How is Catecholamine Activity Assessed? How Does the Body Store Energy? How Prevalent is Hospital Malnutrition?

An adequate index is provided, and the book has a hard cover. This remarkably useful and unique little volume impresses your reviewer as somewhat overpriced.

W. D. SNIVELY, JR., M.D.
Internal Medicine
Evansville

NUTRITION AND THE HOSPITALIZED PATIENT

John W. Broviac, M.D.
E. W. Sparrow Hospital
Lansing, Michigan
Asst. Prof. of Medicine
Michigan State University
East Lansing, Michigan

Alexander E. Nehme, M.D.
Educational Chief of Surgery
Hurley Medical Center
Flint, Michigan
Asst. Prof. of Surgery
Michigan State University
East Lansing, Michigan

Mitchell V. Kaminski, Jr., M.D.
Clinical Prof. of Surgery
University of Health Sciences
Chicago Medical School
Director
Midwest Nutrition Education
and Research Foundation
St. Mary of Nazareth Hospital Center
Chicago, Illinois

Anne L. Winborn, R.D.
Research Dietitian
Metabolic Support Service
St. Mary of Nazareth Hospital Center

NUTRITION SUPPORT TEAM

Judene Bartley, M.P.H.
Charlotte Gibson, R.D.
Sherry Goodfellow, M.S., R.D.

Connie Hagelshaw, M.S., R.D.
Walter Hickey, R.Ph.
Hope McCracken, R.Ph.

Denise Rumsey, R.D.
Hurley Medical Center
Flint, Michigan

Saturday, December 2, 1978 – 9:00 a.m. - 3:45 p.m.

Approved for Six Category I hours

HURLEY MEDICAL CENTER

For further information call or write: **Richard D. Garlick**
Director of Continuing Medical Education – Hurley Medical Center
Sixth Avenue and Begole Street – Flint, Michigan 48502 (313) 766-0142

Sponsored By: **Hurley Medical Center Nutrition Support Team,**
Department of Continuing Medical Education and **Norwich-Eaton Pharmaceuticals**

BOOK REVIEWS

Review of Medical Pharmacology—6th Ed.

Frederick H. Meyers, M.D., et al, Lange Medical Publishers, Los Altos, Calif. 94022. Copyright 1978. 762 pages, \$14.50.

The authors have emphasized those aspects of pharmacology beamed at the clinical needs of medicine, dentistry, nursing, and pharmacy. Their primary objective is to foster a skeptical attitude toward all new drug claims and toward periodic reevaluation of previously used drugs.

The book is subdivided into eight parts, including general information, autonomic and cardiovascular drugs, central nervous system drugs, systemic drugs, endocrine drugs, agents used in nutritional and metabolic derange-

ments, chemotherapeutic agents, and, finally, a section on toxicology.

The writing is lucid and supplemented by an adequate number of tables, line drawings, and graphs. The appendix includes a helpful tabulation of the effects of drugs on common clinical laboratory procedures.

The index is adequate, the flexible binding sturdy, and the price remarkably reasonable. The book is strongly recommended for its target audience.

W. D. SNIVELY, JR., M.D.
Internal Medicine
Evansville

Business Opportunities: Tax Shelters For Professionals

If you're in a higher tax bracket, you'd probably like to reduce your present tax liabilities without reducing income. There is a way.

Tax free municipal bonds offer distinct advantages over other investments. In addition to high yields and tax free income, you also get low risk, diversity, capital appreciation, and marketability.

Many of the investments we offer are Indiana issues which are exempt from Indiana Intangibles Tax plus Indiana Gross Income Tax. At American Fletcher there is no annual management fee or commission charged on municipals. For a small fee (tax deductible) our Safekeeping staff will clip and collect your coupons for deposit to your checking or savings account.

American Fletcher can help. Our Portfolio and Money Market Group can acquaint you with the investment opportunities available in municipal bonds.

Call us today at (317) 639-8070 or address inquiries to: Portfolio and Money Market Group, American Fletcher National Bank, 101 Monument Circle, Indianapolis, Indiana 46277.

**"Give your income a shot
in the arm with tax free
Municipal Bonds from
American Fletcher."**

We want to be your bank.

**AMERICAN FLETCHER
NATIONAL BANK
AFNB**

NEWS NOTES

Physician Community Service Award

Dr. Thomas O. Middleton, a pediatrician from Bloomington, received ISMA's annual "Physician Community Service Award" during last month's annual convention in Clarksville. Dr. Middleton has actively supported and promoted mother and infant and community health at both state and local level, served as health chairman for the Indiana Congress of Parents and Teachers, and participated in planning and examining the health needs of the school-age child. In addition, he helped form the Monroe County Probation Advisory Council, worked with the Stone Belt Council for Retarded Citizens, Inc. in the Special Olympics, helped develop a multi-county conference on school-aged parents which has been very successful, and was instrumental in developing Middle Way House to help persons with drug problems and to provide them an educational program. The award is sponsored each year by the A. H. Robins Pharmaceutical Company.

Annual Journalism Awards

A Rensselaer newspaperman and a Fort Wayne television reporter received the annual ISMA Journalism Awards during last month's annual ISMA convention in Clarksville. O'Ryan Rickard, editor of the Rensselaer Republican, received the award in the print media category for his series of articles about federal health planning guidelines. Marilyn Moran of WKJG-TV, Fort Wayne, received the award in the broadcast media category for her eight-part "To Your Health" series about the heart.

These awards are presented each year at the annual convention of the ISMA following a review of material submitted by the news media through county medical societies to the ISMA Commission on Public Relations.

Lilly Developing Human Insulin

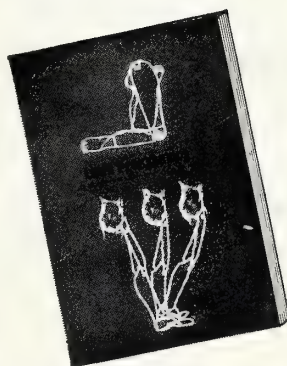
Eli Lilly and Company has begun a long-range development aimed at the eventual commercial production of human insulin by the recently discovered process which depends on recombinant DNA technology. Scientists at Genentech of California have successfully inserted a synthetic gene into the bacterium, *E. coli*. When this altered bacterium is grown in culture, it produces insulin which is now believed to have a structure identical to human insulin. Large scale production of this type of insulin will lessen the dependency on the original process of extraction from animal pancreatic tissue. A form of insulin that is identical to human insulin would, naturally, eliminate any possible side effects which might develop from antibody formation due to use of insulin from swine or cattle.

"You and Your Doctor" Pamphlet

Hot off the press is a new ISMA-produced pamphlet, "You and Your Doctor." It deals with selecting a personal physician, fees and house calls, examination and consultation, and health insurance. It is intended primarily for distribution to newcomers. Initially, copies have been sent to each county medical society for review, in hopes that they will be found acceptable for distribution to Welcome Wagons and Chambers of Commerce. Many other uses are anticipated. Requests for the pamphlet, developed by the ISMA Commission on Public Relations, should be addressed to the Director of Communications, ISMA, 3935 N. Meridian St., Indianapolis 46208.

Vet Benefits Now on Cassette

The VA basic booklet on veterans' benefits has been recorded by the Blinded Veterans Association on cassette tapes for use by the blind. Write the BVA at 1735 DeSales St., N.W., Washington, D.C., 20036. There are two cassettes, which cover six hours of information.



**HANGER PROSTHESES OFFERS
BOOKLET ON AMPUTATIONS**

This booklet has been designed for those physicians whose practice includes amputation. **Limb Prosthetics** gives ready reference for each site of amputation as well as the prostheses recommended for each site.

Over 100 years of experience gained by the Hanger organization have gone into this carefully illustrated booklet. Illustrations include amputation sites for the leg and the arm, various Hanger prostheses and methods of suspension, post-operative care and preparation for prosthesis, plus selected photographs showing the child amputee and training for the above-knee patient.

We believe that you will find **Limb Prosthetics** a most useful booklet and a valuable source of quick information. To obtain your copy, please write or phone the Hanger office nearest you.

Hanger
PROSTHESES

1332 N. Illinois St., Indianapolis, Indiana 46202
312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

NEWS NOTES

Physician Recognition Awards

The following Indiana physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Baker, Sammie Bruce; Evansville
Beck, Robert E.; Evansville
Bossard, John W.; Ft. Wayne
Broadie, Thomas Allen; Indianapolis
Caldwell, Milton Victor; Terre Haute
Camarata, James Charles; Marion
Cowen, Richard Leslie; Evansville
Craig, Richard Morton; Ft. Wayne
Cronin, H. Joseph; Indianapolis
Daftary, Mostafa; Greensburg
Dormire, Robert Darrell; Ft. Wayne
Edler, Robert William; Bedford
Elliott, Daniel Robert; Indianapolis
Fitzgerald, William Joseph; Indianapolis

Gomez, Cesar Morales; Hammond
Hadley, David; Indianapolis
Hendrix, Charles E.; Vincennes
Hill, Theodore Albert; Michigan City
Hogle, Frank D.; Michigan City
Keplinger, James Ellis; Lafayette
Kim, Yong Jun; Marion
Larson, Michael Stephen; Munster
Leipold, Jon David; South Bend
Lessure, Alfred P.; Evansville
Loewenstein, Werner L.; Terre Haute
Loh, Hwei-Ya Chang; Gary
Mason, Richard L.; Hammond
Mathews, James R.; Evansville
Molstad, Clay Leon; Lafayette
Moore, Donald Charles; Columbus

Neal, Leonard Wilson; Munster
Pangalangan, Arturo Lim; Marion
Parks, Herbert Eugene; Indianapolis
Salama, Ramsis Hassib; Indianapolis
Seal, Perry Francis; Brookville
Sherman, David Emery; Lafayette
Skiles, Melvin James; Madison
Smith, Charles Felps; Kokomo
Stewart, L. Ray; Evansville
Stuntz, Edgar Cheadle; Lafayette
Vivian, Donald E.; New Castle
Von Der Haar, Gerard A.; Indianapolis
Wiesert, Kenneth N.; Indianapolis
Yune, Heun Yung; Indianapolis

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

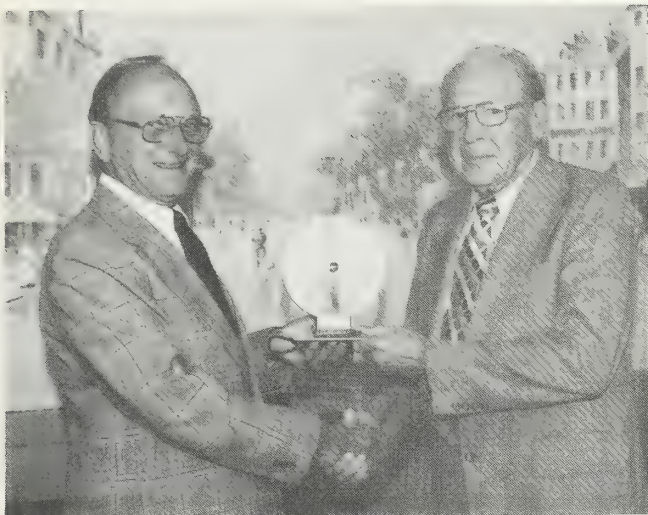
Since 1899

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Southern Indiana Office: Kenneth W. Moeller, Representative
1810 Broad Ripple Avenue Telephone: (317) 255-6525
Mailing Address: P.O. Box 20132, Indianapolis 46220
Northern Indiana Office: Douglas O. Sellon, Representative
120 LaSalle West Bldg., Suite 304
South Bend, In. 46601 Telephone: (219) 289-7332

NEWS NOTES



Jack V. Curtis, left, sales representative for Abbott Pharmaceutical Products Division, presents an award to Dr. John S. Huoni of Jeffersonville, commemorating Dr. Huoni's "50 years of outstanding service and dedication to medicine." The presentation took place in Jeffersonville in September.

Muncie Physician Honored

Dr. Thomas M. Brown of Muncie headed the list of service recognition award winners from the Delaware County unit of the American Heart Association during that group's 30th annual meeting in September. Dr. Brown received a silver tray from the Association's Indiana Affiliate in recognition of 25 years of service.

Jogging Expert on Radio

Dr. John F. Moe of Indianapolis, a family physician, is now being heard on radio station WFBQ in the Circle City. His daily one-minute question-and-answer segments are devoted to all aspects of jogging, and how jogging relates to general and cardio-vascular health.

Dr. Ahler Appointed

Dr. Kenneth J. Ahler of Rensselaer has been appointed to the Indiana State Committee on the Examination of Infants for Inborn Errors of Metabolism. The appointment was made by Governor Otis R. Bowen, M.D. Dr. Ahler is the Jasper County Coroner and the chief of staff at Jasper County Hospital.

Evansville AMEP Publishes Directory

The Addiction Medical Education Program (AMEP) of Evansville has published a "Directory of Addiction Services for Southwestern Indiana," a booklet that lists information, including AA meetings, about Alcoholics Anonymous, Alanon and Alateen. It supplies information about the AMEP program. It also devotes a page to each of the entities in the district which furnish Addiction Services. This list includes most of the hospitals. There is a cross index for most requested services. Copies of the directory may be obtained by writing AMEP at P.O. Box 3287, Evansville 47732.

Urology Films Available

Norwich-Eaton Pharmaceuticals has 10 new educational films on urology. Three of the films won the American Urological Association Motion Picture Awards. All are 16 mm, color and sound. A listing and free loan of the films may be obtained by writing Norwich-Eaton Film Library, Norwich, N.Y. 13815.

New Medical Director for VA

Dr. James C. Crutcher has been appointed chief medical director of the Veterans Administration. He succeeded Dr. John D. Chase, who retired July 28. Dr. Crutcher, a board certified internist, served in the Navy as an enlisted man in World War II and then served in the Army Medical Corps in Korea. His VA service includes 26 years at the Atlanta VA Hospital.



McClain Car Leasing, Inc.

1745 Brown St., Anderson, Ind.

Phone 317/642-0261

Specializing in Professional Car Leasing

ALL MAKES AND MODELS AVAILABLE

We are proud to offer a Leasing Plan approved by ISMA

NEWS NOTES

Directory for Visually Handicapped

The "Directory of Agencies Serving the Visually Handicapped in the U.S." has been published in a new format which provides more complete, specific and useful information about agencies and schools that offer services to visually handicapped persons. The "Directory" is available for \$10 per copy from the American Foundation for the Blind, 15 W. 16th St., New York City 10011.

Gary Doctors Assume Posts

Dr. William F. Nowlin and Dr. Wei-Ping Loh, both of Gary, have been elected to key positions with the Indiana Division of the American Cancer Society. Dr. Nowlin, general surgeon at Gary St. Mary Hospital, was re-elected president of the division. Dr. Loh, chief pathologist at Gary Methodist Hospital, was elected to a one-year term on the division's executive committee.

'Health Highlights' Offered

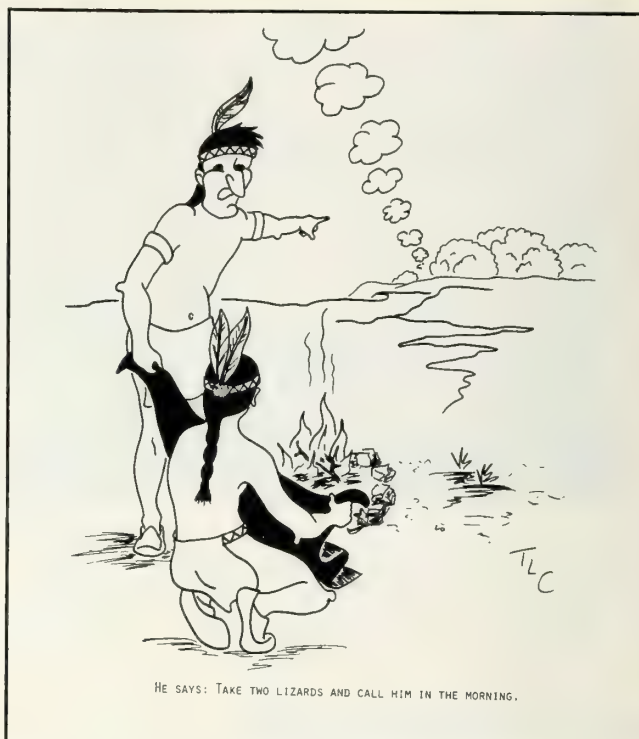
Eli Lilly & Company has started publishing "Health Highlights: Issues and Viewpoints" on a monthly basis. The publication carries factual material on health-care related matters for newspapers, magazines and the broadcast media. The original issue discusses drug prices and presents advice to patients concerning ways to avoid high drug bills.

Hospital Medical Staffs Named

University Heights Hospital—Dr. James M. Hilz, chief of staff; Dr. Bruce H. Bender, vice chief of staff; and Dr. J. P. Worley, secretary-treasurer.

Methodist Hospital of Gary, Inc.—Dr. R. J. Doherty, president; Dr. Leo Roth, president-elect; Dr. Ramakrishnan Unni, secretary; and Dr. Bassem Atassi, treasurer.

Lutheran Hospital, Fort Wayne—Dr. J. Robert Ball, president; Dr. Dan Tritch, president-elect; Dr. Thomas Felger, secretary; and Dr. Richard J. Miller, treasurer.



New Associate Dean

Dr. Robert Daugherty Jr. has been named associate dean of the Indiana University School of Medicine. Dr. Daugherty, who has been dean of medicine at the University of Wyoming, will direct the Indiana division of postgraduate and continuing medical education. He also will coordinate the school's master's and PhD programs with the I.U. graduate school.

Professor of Faculty

Dr. Carl B. Sputh, Indianapolis, served as Professor of Faculty for 15 doctors from the American, Mexican and European Rhinologic Societies who participated in an international course on "Corrective and Functional Surgery of the Nasal Septum and Bony Pyramid." It was presented in July at the University of Bologna in Italy.

INDIANA MEDICAL BUREAU

1010 East 86th St.—72 Winterton

Indianapolis 46240

844-7933

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 26th Year of Service

100 mg

250 mg

500 mg



Tolinase[®]

tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

© 1977 THE UPJOHN COMPANY

PHYSICIANS' DIRECTORY

INTERNAL MEDICINE

Offices for the doctors listed below are located at 3130 N. Meridian St., Indianapolis 46208; the switchboard number is 317-927-1221.

MERIDIAN MEDICAL GROUP

CARDIOLOGY

Richard M. Nay, M.D.
Warren E. Coggeshall, M.D.
Richard R. Schumacher, M.D.
William C. Elliott, M.D.

HEMATOLOGY—ONCOLOGY

Laurence H. Bates, M.D.
William M. Dugan, M.D.
James E. Schroeder, M.D.
Frank A. Workman, M.D.
Deborah S. Provisor, M.D.
Pediatrics

METABOLISM AND

ENDOCRINOLOGY
William M. Holland, M.D.

GASTROENTEROLOGY

Robert D. Pickett, M.D.
B. T. Maxam, M.D.
Lee G. Jordan, M.D.
Martin P. Meisenheimer, M.D.

INTERNAL MEDICINE

Hunter A. Soper, M.D.
Douglas H. White, Jr., M.D.
Michael B. DuBois, M.D.
Nephrology
Michael P. Bubbs, M.D.
Robert L. Iverson, Jr., M.D.
Critical Care
Michael Zeckel, M.D.
Infectious Diseases

INFECTIOUS DISEASES

Thomas G. Slama, M.D.
NEUROLOGY
Norman W. Oestrike, M.D.
Charles Rehn, M.D.

NEUROSURGERY

By Appointment

Phone 925-4255

C. BASIL FAUSSET, M.D.

Neurological Surgery

1815 North Capitol Avenue

Indianapolis 46202

By appointment only

Phone 317-353-6800

BIO MEDICAL LABORATORY

5506 East 16th St., Suite 24
Indianapolis 46218

Bio-Feedback Training for Migraine and Tension Headache
KARL L. MANDERS, M.D.

JOHN S. MARKS, JR., M.D.

MALCOLM S. SNELL, M.D.

PLASTIC SURGERY

NEPHROLOGY & INTERNAL MEDICINE, INC.

Daniel J. Ahearn, M.D.

Thomas Wm. Alley, M.D., FACP

George W. Applegate, M.D.

Charles B. Carter, M.D.

William H. Dick, M.D., FACP

Theodore F. Hegeman, M.D.

Douglas F. Johnstone, M.D.

LeRoy H. King, Jr., M.D., FACP

2020 W. 86th St., #307, Indianapolis 46260 Ph: 317-844-9911
1633 N. Capitol, #722, Indianapolis 46202 Ph: 317-926-0757

Answering Service 926-3466

CLINICAL NEPHROLOGY, RENAL TRANSPLANTATION, HEMODIALYSIS, PERITONEAL DIALYSIS, HYPERTENSION, FLUID AND ELECTROLYTE IMBALANCE, CRITICAL CARE.

PLASTIC & HAND SURGERY CLINIC, INC.

1944 N. Capitol Ave.

Indianapolis 46202

"An office surgery facility"

Haroon M. Qazi, M.D.

Diplomate, American Board of Plastic Surgery

Phone: 317-923-4822

317-926-3466

HAND SURGERY

By appointment

Phone 317-783-1319

VIDYASAGAR S. TUMULURI, M.D., F.A.C.S., INC.

Diplomate American Board of Surgery

Acute & Reconstructive Hand Surgery
General Surgery

3530 S. Keystone, Suite 305

Indianapolis 46227

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

PHYSICIANS' DIRECTORY

PSYCHIATRY

JOHN H. GREIST, M.D.

Diplomate, Board of Neurology and Psychiatry

Specializing in Psychiatry

3231 North Meridian Street

Indianapolis 46208

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALCOHOLISM TREATMENT

GERALD P. JOHNSTON, M.D.
BRADLEY N. BOEN, M.D.
PAUL M. FLANAGAN, M.D.
HAROLD G. NICHOLS, M.D.

Comprehensive Alcoholism Treatment

Fairbanks Hospital
1575 Northwestern Avenue
Indianapolis, Ind. 46202

(317) 638-1574

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALLERGY

INDIANA ASTHMA & ALLERGY ASSOCIATES

Specializing in Chronic Severe Asthma

and

Adult and Pediatric Allergic Disorders

D. Duane Houser, M.D., Inc.

(317) 923-7650

and

Douglas J. Horton, M.D.

(317) 923-6990

1815 N. Capitol Avenue
Indianapolis, Indiana 46202

Diplomates, American Board
of Allergy & Immunology

Answering Service 926-3466

CARDIOLOGY

William K. Nasser, M.D. and Michael L. Smith, M.D. are pleased to announce the addition of Cass A. Pinkerton, M.D. for the practice of cardiology and cardiac catheterization.

8402 Harcourt Road, Room 413
St. Vincent's Professional Building
Indianapolis — (317) 257-9316

COLON AND RECTAL SURGERY

VINCENT C. SCUZZO, M.D., F.A.C.S.

Certified: American Board of Colon and Rectal Surgery
Associate Fellow: American Society of Colon and Rectal Surgeons
Specializing in Colon and Rectal Surgery

214 Sherland Building
105 East Jefferson Blvd.

South Bend, Ind. 46601

OBITUARIES

Frederick W. Buechner, M.D.

Dr. Buechner, 78, a South Bend general practitioner, died Sept. 14 in that city's Memorial Hospital.

A 1928 graduate of the Indiana University School of Medicine, he was an Army veteran of both world wars. He had practiced in South Bend since 1929 and had developed a special interest in helping the poor.

In 1961, Dr. Buechner was named "Physician of the Year" by the St. Joseph County Medical Society. He became a member of the ISMA 50-Year Club this year.

Dale L. Carlberg, M.D.

Dr. Carlberg, 68, a Jeffersonville physician, died Aug. 27 in Clark County Memorial Hospital.

Dr. Carlberg, a native of Berwick, Pa., had lived and practiced in Jeffersonville since 1940, a year following his graduation from Hahnemann Medical College of Pennsylvania.

He was a Fellow of the American Academy of Family Physicians and was a member of the American Academy of Physicians and Surgeons.

Dr. Carlberg, a former chief of staff at Clark County Memorial Hospital, was a past president of the Clark County Medical Society.

Raymond R. Calvert, M.D.

Dr. Calvert, 79, a Lafayette ophthalmologist, died Aug. 23 in Lafayette Home Hospital.

A senior member of the ISMA, he was a 1927 graduate of the Indiana University School of Medicine. Dr. Calvert, who lived in Monticello, had retired from active practice in 1976.

A veteran of World War I, he was a member of the American College of Surgeons and the International College of Surgeons. He was a Fellow of the American Academy of Otolaryngology and was certified by the American Board of Ophthalmology.

Milton F. Popp, M.D.

Dr. Popp, 70, a practicing physician and surgeon in Fort Wayne and Grabill, died Aug. 16 in Parkview Memorial Hospital, Fort Wayne.

Dr. Popp, who was born in Fort Wayne, was a 1934 graduate of Northwestern University School of Medicine.

He was a member and past president of the Allen County Medical Society and was a Fellow of the American College of Surgeons.

During World War II, Dr. Popp served in the Navy as a flight surgeon.

LETTERS

Supports Crane's Campaign

To the Editor:

David Crane, M.D., Republican candidate for Congress from the 6th District of Indiana, has been endorsed by Our United Republic Political Action Committee (OURPAC) and was the recipient of \$750 from this non-partisan alliance of doctors, dentists, patients, pharmacists, nurses and veterinarians opposed to government interference in medical care.

The presentation was made Aug. 2 at a Johnson County Medical Society dinner meeting at Vallee Vista Country Club, Greenwood, by Dr. Joseph W. Young.

Dr. Crane supports the free-choice American system of private medical care and is opposed to so-called "national health insurance," the most inflationary big spending scheme of all, Dr. Young said.

Letters will be published as space permits and at the discretion of the editor. They will be subject to editing. Reader response is encouraged. Letters should be addressed c/o THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

OURPAC was organized to support candidates who will vote to save the American non-political private medical system. Dr. Crane, along with other OURPAC-supported candidates, will fight big-spending politicians who want to force us down the same road to destruction that England is following—which has resulted in a crippling 30% inflation, shoddy and impersonal medical care, six-month to two-year waiting lists for hospital admission, and skyrocketing taxes.

Contributors will be pleased to know that OURPAC will send \$200 to Dave Crane's campaign for each \$100 contributed to OURPAC, subject to limitations of the law and available funds. This is possible because OURPAC is soliciting funds throughout the country and channeling these for maximum effect to Congressional candidates who need help to win and who are committed to free-choice principles.

Contributions can be sent to OURPAC, Box 94525, Chicago, Ill. 60690.

HELEN B. BARNES, M.D.
Chairman, Indiana OURPAC
Greenwood

COMMERCIAL ANNOUNCEMENTS

Commercial announcements are carried in The Journal as a special service to ISMA members. Only advertisements considered by publisher to be of advantage to members will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

20¢ for each word

\$4.00 minimum

Send cash with order. Average count: seven words to the line.

Address: The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

DEADLINE: Fifth day of month PRECEDING month of issue.

TWO BOARD CERTIFIED FAMILY PHYSICIANS need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please send curriculum vitae to Link, Chapman & Associates, Inc., 1515 W. Truman Road, Independence, Missouri 64050, or call collect (816) 836-8200 between 9 a.m. and 4:30 p.m.

MICHIGAN CITY, INDIANA—Emergency Department Director; flexible scheduling. Excellent income—\$57,000 to \$65,000. Paid malpractice insurance. Contact T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, Missouri 63141, or call toll free 1-800-325-3982.

EMERGENCY DEPARTMENT DIRECTOR NEEDED—Modern community hospital with excellent work surroundings, near Cincinnati. 17,000-20,000 patient visits per year. Annual salary and benefits total from \$66,000-\$68,000. Some residency training and administrative experience helpful, but not necessary. Interested parties should call collect Dr. G. T. Bowen, M.D., Dearborn County Hospital, Lawrenceburg, Ind. 47025. (812) 538-1010.

EMERGENCY MEDICINE: Seeking career-oriented emergency physician to complete group of four. Community hospital with 330 beds and 30,000 emergency department visits per year. Malpractice insurance provided. Fee for service compensation. Contact Paul Laudick, St. John's Hospital, 2015 Jackson St., Anderson, Ind. 46014.

OPPORTUNITIES FOR PHYSICIANS—There are several excellent openings among the Indiana State Hospitals at various locations throughout the State for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Candidates must be licensable in Indiana. Please reply with a copy of the c.v. to: FARABEE & ASSOCIATES, INC., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

THE INDIANA STATE DEPARTMENT OF PUBLIC WELFARE has a position available for a physician to work in a pleasant office atmosphere; no patient contact; no malpractice insurance required; an Indiana license or eligibility is required; competitive salary; regular working hours; excellent fringe benefits. Contact: Personnel Director, Indiana State Department of Public Welfare, 702 State Office Building, 100 N. Senate Ave., Indianapolis 46204. Phone: (317) 633-6403.

FOR LEASE: On Vanderbilt Beach near Naples, Fla., two-bedroom, two-bath new condominium on the beach. Docking facilities available. Tel: (317) 644-6147.

RETIRED or physically restricted or limited practice physicians as **MEDICAL DIRECTORS** of plasma center in West Lafayette area. Call Mr. Reiland at (317) 924-6336, PLASCON, INC.

POSITION AVAILABLE—Excellent opportunities within an ever growing and creative education program, involving patient/doctor relationships among a 30-physician residence of a large teaching institution. Immediate occupancy is available for an Associate Director of Family Practice Education. This Center is located in new facilities in a new 12-story tower adjacent to the main 1150-bed teaching hospital. Write and send resume to: Director of Family Practice Education, Methodist Hospital, 1604 N. Capitol Ave., Indianapolis, Ind. 46202.

NEEDED: Creative physician educator to assume an excellent position and opportunities as Associate Director of a Family Practice program, which is part of a 30-physician residency. This Center is located within the new Medical Tower adjacent to an 1150-bed teaching hospital in Indianapolis, Ind. Excellent salary and benefits available. For further information, send CV to: Director of Family Practice Education, Methodist Hospital, 1604 N. Capitol Ave., Indianapolis, Ind. 46202.

TWO YOUNG GENERAL INTERNISTS seeking replacement for departing third member of group. Busy, established practice. Board certification or eligibility required. Send CV to Logan Internists, Inc., Suite A, 1201 Michigan Ave., Logansport, Ind. 46947.

INTERNIST OR GENERAL PRACTICE PHYSICIAN for the staff of a Health Care Facility in a city of 43,000 in north central Indiana. Permanent license in any U.S. state required. Salary open to \$47,025 depending on qualifications and experience. Special bonus pay is available in addition. Thirty days vacation; 15 days sick leave; 9 paid holidays; low-cost life and health insurance; malpractice insurance furnished; excellent retirement plan. Moving expenses paid. EOE. Contact: Personnel Service, VA Medical Center, Marion, Ind. 46952. Tel: (317) 674-3321, ext. 419 Collect.

BEAT THE WINTER—Come to the sunbelt. Our clients range from solo practitioners seeking associates, to single and multispecialty group expansions, to practices being vacated by retiring physicians. These situations offer excellent growth, low crime, warm climate, varied recreational activities, and attractive income and perk packages. For assistance in your move and/or opportunities in your specialty, send your CV, describing the situation you seek, to MEDICAL SEARCH, 3955 Pleasantdale Road, Atlanta, Georgia 30340.

PHYSICIANS WANTED—A progressive rural community in midwestern Indiana desires to secure two or more general practitioners. Interested parties would find new schools, a new nursing home, new banks, good hospitals nearby, etc. A medical center with purchase option will be built to accommodate these physicians. Contact J. D. Piech, 1600 E. Liberty, Covington, Ind. Tel: (317) 793-4818.



"Efficiency is the key to your practice"
 Graduates of P. C. I. are thoroughly trained
 in the most up-to-date methods as Medical
 Assistants (AMA accredited) and Medical
 Receptionists.

PROFESSIONAL CAREERS INSTITUTE

6321 La Pas Trail, Indianapolis, IN 46268
 Telephone: (317) 299-6001

Are You Moving?

If so, please send change of address to Membership
 Dept., ISMA, 3935 N. Meridian St., Indianapolis, IN
 46208, at least six weeks before you move.

Name

Address

City State Zip

County

IMPORTANT — Attach mailing label from your last
 Journal here.

ADVERTISERS IN THIS ISSUE

November 1978

Vol. 71

No. 11

American Fletcher National Bank1088

Beltone Electronics Corp.1039

Blue Cross-Blue Shield1025

Brown Pharmaceutical Co., Inc.1057

Burroughs Wellcome Co.1052

Dave Waite Leasing1078

Hanger Protheses1089

Hurley Medical Center1087

Indiana Medical Bureau1092

Lilly, Eli and Company, Inc.1037

McClain Car Leasing, Inc.1091

Mead Johnson Pharmaceutical Div. ..1061, 1062

Medical Protective Company1090

Merrell-National, Inc.1032-1034, 1042,
1050-1051

Morris Plan1050

Professional Careers Institute1098

P&SLI1073

Purepac Pharmaceutical Co.1029

Roche LaboratoriesCovers, 1023-1024,
1040-1041

Rockwood Insurance Company1049

Smith, Kline & French1031, 1070-1071

The Pointe1027

The Upjohn Company1093

Townsend, J. Russell and Associates1085

U.S. Air Force1045

U.S. Navy1040

In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

INDIANA STATE MEDICAL
ASSOCIATION JOURNAL

Seasons Greetings

December 1978 • Vol. 71 • No. 12

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

U. of Calif., San Francisco
SAN FRANCISCO, CA 94143

SANTA CLAUSLAND
INDIANA

LIBRARY
U.C. SAN FRANCISCO

DEC 29 1978

THE MESSAGE OF TENSION

HEADACHES
SWEATS
TENSE, TAUT MUSCLES
HYPERVENTILATION
TACHYCARDIA
PALPITATIONS
BURNING IN STOMACH
FULLNESS
FREQUENCY

to relieve psychic tension
and its functional symptoms

VALIUM®
(diazepam) (V)

2-mg, 5-mg, 10-mg scored tablets

VALIUM® (diazepam)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, ataxic, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia.

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis



Dr. Joseph E. Milburn, seated; his son, Dr. Robert C. Milburn, center; Robert's son, Joseph, left.

Mr. and Mrs. Robert N. Stillwell of St. Louis, Missouri recently donated items to the Museum which were used by Mr. Stillwell's grandfather (Robert C. Milburn, M.D.) and great-grandfather (Joseph E. Milburn, M.D.).

Both men were Indiana physicians.

Joseph E. Milburn was born Jan. 25, 1827 on a farm near Aurora, Ind. Nine years later he moved with his family to Clinton County, where his father bought a farm. Joseph was only 14 when his father died. Being the only son in the family of five children, the father's death left Joseph to be the man of the family. In spite of his farming responsibilities, he was able to obtain a rudimentary education in the one-room log schoolhouse of the time.

In the autumn of 1848, at the age of 21, Joseph commenced the study of medicine under the guidance of Dr. William Byers of Frankfort. Following his apprenticeship, Joseph attended lectures at

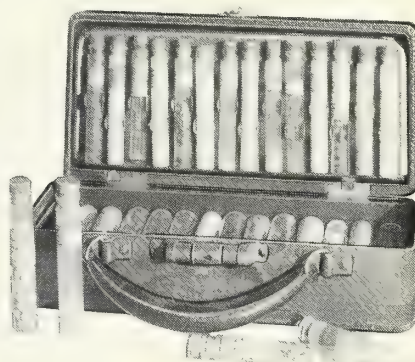
Rush Medical College in Chicago during the winter months of 1851 and 1852. In the fall of 1852 he located in Midway, Ind. (now Colfax), where he practiced until his death Oct. 23, 1912.

Robert, the only son of Dr. Joseph and Melinda (Caldwell) Milburn, was born July 14, 1858. He also attended Rush Medical College (1880, 1881, and 1882). He then practiced medicine at Logansport, later at Elwood, and then finally at Muncie. He died in July 1938.

The items donated to the Museum, in addition to the portrait on this page, include Dr. Joseph Milburn's saddle bags and Dr. Robert Milburn's pill case. It is of interest to recall that the two generations represented by these men covered the various modes of transportation from horseback, the horse and buggy, and the automobile to a high state of development.

Other items donated to the Museum include a set of obstetrical forceps, so shiny and well cared for

that they appear to be brand new, rather than over a century old. Dr. Robert Milburn's matriculation cards from Rush Medical School of 1880, '81, and '82 are also included. Information about the family is contained in a copy of the COLFAX STANDARD for Friday, June 28, 1912, which gives the obituary of Dr. J. E. Milburn.



Pill case used by Dr. Robert Milburn.

Mr. and Mrs. Robert Stillwell delivered these various items personally. We are very grateful for their interest in the Museum.



Saddlebags used by Dr. Joseph Milburn.

WHAT'S NEW?

Research Industries Corporation of Salt Lake City is marketing a new drug: DIMETHYL SULFOXIDE (DMSO), trade name RIMSO-50. The FDA clearance allows the drug to be used in treatment of interstitial cystitis. The drug is dispensed as a sterile and pyrogen-free solution. Treatment is by installation of 50 ml of the solution with retention for 15 minutes. There is no evidence that RIMSO-50 is effective in bacterial infections of the urinary tract.

* * *

Bristol-Myers has FDA approval to market Stadol® (butorphanol tartrate), a new, highly potent, injectable analgesic for the relief of moderate-to-severe pain. Stadol is not classed as a narcotic and is not thought to be addictive. In double blind comparative clinical trials Stadol compares favorably with morphine and Demerol in pain relief potential.

* * *

The 3M Company is finding new uses for Coban brand Elastic Bandage. It not only serves as a dressing overwrap but is also convenient for hard-to-bandage areas like fingers and limbs. It will secure indwelling vascular catheters or cannulas. It has nonslip properties and may be cut to size for areas such as around fingers. Coban elastic bandages were originally devised for supporting sprains and strains and for edema control.

* * *

Searle is introducing Diulo (metolazone), a diuretic effective in treatment of hypertension. Diulo is an entity well suited for initial treatment. It is highly effective with a single daily dose. It will be available in 2½ mg., 5 mg., and 10 mg. tablets in bottles of 100.

* * *

Marion Laboratories introduces GAVISCON® Liquid Antacid. It has a non-chalky taste, spearmint flavor and smooth texture. Like the tablets the liquid has a unique foaming action which forms a protective layer in the stomach.

* * *

Abbott Laboratories is introducing a new development for burn treatment called Hydron Burn Bandage. It is a unique, synthetic, spray-on bandage which is a barrier but allows passage of water vapor out and permits absorption of water-soluble antibiotics through the dressing. The dressing is transparent and flexible and in most cases reduces pain.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

Lumex, Inc., makers of Quad Canes, has a new line with improvements over its already popular standard models. The new models come with either large or small bases. Both bases have rolled edges to prevent bruising and scraping of ankles. They also feature texturized finish to reduce glare, adjustable height range from 29" to 38", and four rubber tips.

* * *

The newly introduced Vitalograph Resuscitator is a hand-powered resuscitator of the self-filling bag type. The bag is natural rubber and is large enough to provide sufficient inflation with one hand. There is an audible controlled leak from the inflating valve body if undue resistance is encountered.

* * *

Upjohn Diagnostics announces a new testosterone assay kit that accurately measures levels in blood fluids or urine. It will detect amounts as small as two trillionths of a gram. In males, testosterone tests are important in impotence, in delayed or precocious puberty, and in hypogonadism. In females, they aid in diagnosing hirsutism and virilization and in determining the cause of polycystic ovary.

* * *

Merck Sharp & Dohme have released supplies of "Timoptic" (timolol maleate), a new drug for the treatment of glaucoma. The drug, unlike presently used glaucoma drugs, causes little or no blurring of vision, burning or irritation of the eye or night blindness. The dosage is one drop in the eye twice daily, and in some cases only once a day. "Timoptic" is approved for treatment of chronic open-angle glaucoma.

* * *

Cooper Laboratories research has discovered a new chemical agent for control of dental plaque. The new chemical—CK-0569—has been effective in animal testing and in initial human tests. Further research is under way to determine whether control of plaque by the chemical will prevent gum, bone and tooth diseases considered to be complications of plaque formation.

* * *

A New Zealand designer has won an inventors' award and a cash prize for designing a new incubator for premature babies. "Premicare" has an external fan and motor to control the noise within. The temperature control maintains constant temperature even when the ports are open. Humidification is kept at a standard level by an externally mounted water tank and humidifier. The infant need not be disturbed when X-rays are taken. The interior is designed to minimize cleaning chores.

* * *

IN BOOKS . . .

W. B. Saunders has just released "You and Leukemia, A Day at a Time." It is the revised edition of a book by Lynn S. Baker, M.D., for patients and families. The

CONTINUED ON PAGE 1109

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of
Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Contents

SCIENTIFIC ARTICLES

- 1129 **Why Some Infants Fail to Thrive—**
Morris Green, M.D.
(Twelfth Continuing Medical Education article)
- 1133 **Hypertension X: Renovascular Hypertension—**
Clarence E. Grim, M.D.
- 1136 **Nicotine Addiction: Treatment with Medical Hypnosis**
(Part 2)—*Hanus J. Grosz, M.D.*
- 1138 **Surgical Experience with Pulmonary Tuberculosis Patients**
Receiving Steroids—*Felipe S. Chua, M.D.*
- 1142 **Heel Ulcer Development and Successful Arterial Recon-**
structive Surgery—*Ronald T. Rolley, M.D.*
- 1144 **Tolerance of the Vermiform Appendix to Pressure—**
Richard J. Noveroske, M.D.

EDITORIALS

- 1104 **Survey of Canadian National Health Insurance**
- 1104 **Is American Medicine Noncompetitive?**
- 1110 **On Rights and Justice**
- 1106 **Editorial Notes**

SPECIAL FEATURES

- 1120 **An Old-Time Approach: Dr. Henry R. Shallenberger**
- 1128 **Public Attitude Survey**
- 1161 **The 129th ISMA Convention in Photos**
- 1170 **Proceedings of the House of Delegates**
- 1154 **Dr. Arvine G. Popplewell Named President-Elect**
- 1226 **Constitution and Bylaws of ISMA**
- 1241 **AMA Principles of Medical Ethics**

DEPARTMENTS, MISCELLANEOUS

- | | |
|----------------------------------|-----------------------------------|
| 1099 Medical Museum Notes | 1128 There's a Word for It |
| 1100 What's New? | 1126 Future File |
| 1112 Auxiliary Report | 1148 Book Reviews |
| 1114 Tax Tips | 1152 News Notes |
| 1116 Cancer Corner | 1160 Obituaries |

ABOUT THE COVER

Until Christmas Eve, Santa spends much time sorting his mail. When he replies from his home in Santa Claus, Ind., the town's unique postmark is stamped on all postage. Santa Claus Land, located in southern Indiana, will be open the first three weekends of December. There is an admission charge. PHOTO COURTESY INDIANA DEPARTMENT OF COMMERCE

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue.

Representative for national advertising is the State Medical Journal Advertising Bureau, 711 South Blvd., Oak Park, Ill. 60302.

Annual subscription rates: ISMA members, \$8, included in annual membership dues; ISMA senior members, \$10; Libraries, \$12; all others, \$14. Additional postage: Canada and PUAS countries, \$2; Foreign, \$3. Subscriptions are renewable in July and January.

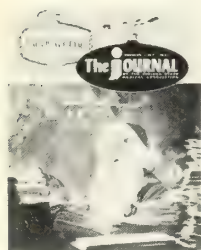
Entered as second class matter January 25, 1933, at the Post-office at Indianapolis, Indiana.

THE JOURNAL of the Indiana State Medical Association (USPS 284-440) is published monthly by the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208. Second-class postage paid at Indianapolis, Ind., and at additional mailing office. No copyright is claimed.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

Our International Standard Serial Number is ISSN 0019-6770.

Indexed in Index Medicus and Hospital Literature Index.



Six important reasons why physicians are selecting the Reality[®] Medical Management System.

1. Improved Cash Flow. Timely patient statements which reflect the detailed account status of charges, payments and aged account balances contributes to faster payments and a reduction of bad debts.

2. Totally Automated Insurance Processing. The Reality Medical Management System has incorporated the processing of Medicare, Medicaid, Blue Cross, Blue Shield and most other third party payors into the automatic billing and insurance claim reporting function, thus, eliminating clerical time, errors and lost charges.

3. Direct Control. No reports, no files, no charge tickets leave your office. Your personnel, who know your method of operations, communicate directly to the computer based system via a video display terminal. Everything is processed according to your schedule and in a manner which fits your Doctor to Patient relationship.

4. Improved Practice Control. From the management reports and practice statistics, your practice can be managed in ways which will more effectively utilize the resources of the practice, thus, generating a better return on your total investment.

5. Better Patient Care. Research by diagnosis can lead to better patient care. The System maintains data by patient, by procedure and by diagnosis, whereby, retrieval and analysis can provide historical treatment histories. Better patient scheduling by the System makes for better patient relations.

6. Communication With The System In English. Unlike other automated systems, the Reality Medical Management System is under your direct control (not through a programmer) in a common language used by human beings — known best as **English**. If you can type, you can talk to the System.

Take A Good Look At Reality. Call Anacomp or send in the coupon today for a free hands-on demonstration. Within 15 minutes you'll know all you need to know about choosing a computer.

Microdata

Attach your business card and send to:

Anacomp
4755 Kingsway Drive
Indianapolis, Indiana 46205

For immediate response,
call **317/257-1426**



Show me.

- ☐ I'd like a free hands-on demonstration of Reality[®].
- ☐ I'd like more information.

EDITORIALS

Survey of Canadian NHI

An interesting and instructive survey has been made on the Canadian National Health Insurance System by Cotton M. Lindsay, an economist of the University of California at Los Angeles. (A grant by Roche Laboratories made the study and Mr. Lindsay's reports possible.)

Lindsay's subtitle to his report is "Lessons for the United States."

His findings are important because the Canadian system is similar to several of the types of national health insurance proposed in Congress for the United States.

Finding No. 1: Contrary to its stated goals, Canada's national health insurance program, financed at the expense of social welfare spending, has not only failed to increase access to medical care for the poor but has raised the cost of medical care for Canadians at all income levels.

Canada's medical system has increased government spending without actually lowering costs to any income group. For every dollar spent for medical care, 60 cents is being displaced from existing social welfare programs. Government spending for medical care per family in 1976 averaged \$1,122, more than 10% of all Canadian government spending. Since their federal and provincial budgets are relatively fixed, other programs have suffered cutbacks to finance health care.

Lindsay points out that the problem of access to medical services cannot be eliminated by reducing the price to zero. There are a fixed number of doctors and hospitals. Consumers, unable to bid for scarce services with money, must wait in line. They pay a part of the price by standing in queues until the time spent in waiting is high enough to limit the quantity of care to that which is available.

Finding No. 2: One of the concerns of a medical service is the concentration of physicians in urban areas and away from rural and depressed areas. In Canada the income levels for physicians are relatively fixed. As a result, Canadian physicians have tended to shift toward more geographically and socially attractive areas. This makes access for care more difficult, not easier.

Finding No. 3: "All you have to do is look at the experiences of the government-run postal system, or the Amtrak take-over," says Mr. Lindsay, "to realize the problems government intervention can create. I shudder to think this type of an experience could be repeated in the American medical care industry."

Is American Medicine Noncompetitive?

"What's RIGHT With American Medicine," an article prepared by Harry Schwartz, a member of the editorial board of the NEW YORK TIMES, appears in the September 1978 issue of READER'S DIGEST.

He points out that, while most of what one reads about American medicine is concerned with its faults, most of which are imaginary, the truth is that the American system is the best in the world. The U.S. death rate is the lowest on record. A baby born in 1976 will live on the average for 72.8 years, a gain of 10 years since 1940; infant mortality has improved so much that today 30,000 babies will live who would have died in 1965.

Schwartz quotes DHEW Secretary Califano as saying that our medical system is "a vast, sprawling, complex, highly expensive and virtually noncompetitive industry."

CONTINUED ON PAGE 1106

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 3935 N. Meridian Street, Indianapolis 46208.

Consulting Editors: A. W. Cavins, M.D., R.R. 25, Box 172, Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1, Box 202, Gaston 47342; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne 46802; I. W. Wilkens, M.D., 4820 E. Pleasant Run Pkwy., N. Dr., Indianapolis 46201; W. D. Snively, Jr., M.D., R.R. 1, Box 227, Evansville 47712; Charles A. Bonsett, M.D., 6133 E. 54th Place, Indianapolis 46226.

Editorial Board:

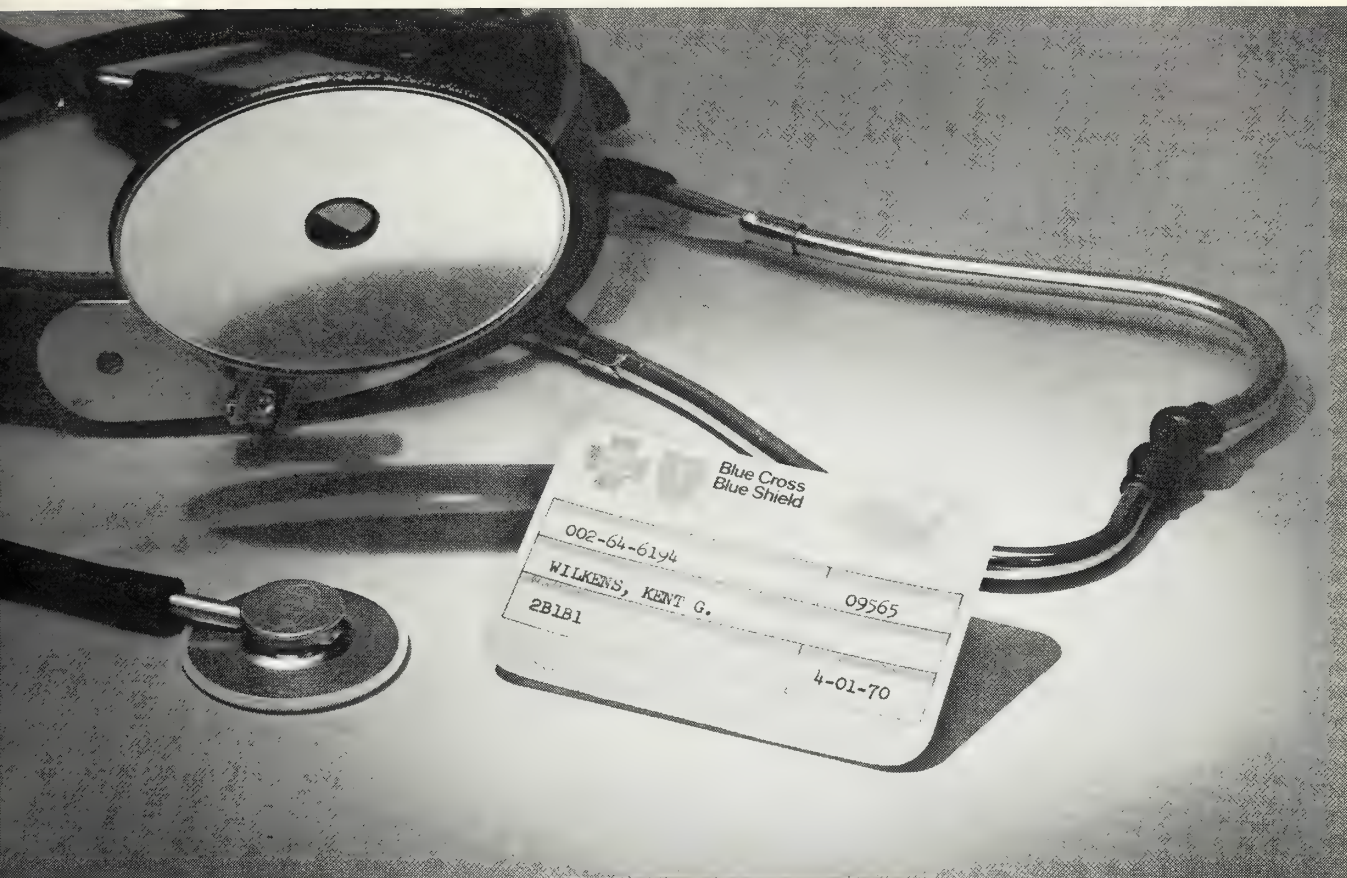
	Term Expires
Steven C. Beering, M.D., Indianapolis	Dec. 31, 1981
Paul S. Rhoads, M.D., Richmond	Dec. 31, 1981
Elton Heaton, M.D., Madison	Dec. 31, 1979
Rodney A. Mannion, M.D., La Porte	Dec. 31, 1979
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1980
Wei-Ping Loh, M.D., Gary	Dec. 31, 1980

Business Manager: Donald F. Foy

3935 N. Meridian, Indianapolis, Ind. 46208

Managing Editor: Martin T. Badger

Take advantage of a great association!



Get these special benefits — available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage — and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association — entitling you to special group rates for these benefits:

- One full year in-hospital care
- 100% semi-private room and hospital extras
- Allowances for surgery, anesthesia, obstetrics, medical visits, diagnostic and radiation therapy
- \$250,000 Major Medical Benefits

That's not all. You also benefit from the immediate recognition and automatic acceptance of the Blue Cross and Blue Shield membership card. The special rates available through the Indiana State Medical Association membership make this coverage your best investment in personal protection. You can get it — now.

Call or write: Mrs. Kathryn Eads,
Professional Accounts, Blue Cross and Blue
Shield of Indiana, 120 W. Market Street,
Indianapolis, Indiana 46204. Telephone: (317)
263-4925.

120 West Market St.
Indianapolis, Ind. 46204

* Reg. Mark Blue Cross Assn.
® Reg. Serv. Mark Nat'l Assn.
of Blue Shield Plans



**Blue Cross
Blue Shield**
of Indiana

Is American Medicine Noncompetitive?

CONTINUED FROM PAGE 1104

Schwartz says we are fortunate that we have such a system because the nation is "vast, sprawling, complex" and needs that type of medical care.

He doesn't take stock in the noncompetitive label. Americans almost always have several hospitals and many physicians to choose from. He also mentions that the type of care typical to HMOs limits the patient's choice. Government medicine of any type also will limit the patient's choice.

Mr. Schwartz realizes that there are rural areas and small towns in America that do not have resident doctors. But he emphasizes that, in a country where each citizen has a free choice as to where he lives, there is no practical way to remedy this geographic problem; and there's no need to either, since rapid transportation almost always solves the dilemma.

Schwartz also is not too impressed with the fancied lack of good medical care in large population centers. He knows of several large, highly competent, and famous medical centers located in the inner cities.

The recurring lament about medicine which, most of the time, is treating illness and not paying any

attention to preventing it, doesn't worry Mr. Schwartz. The people, he says, who incessantly talk this way are really advising physicians and hospitals to tell people to avoid tobacco, avoid obesity, drink moderately or not at all and to exercise more, when, as a matter of fact, all this good advice—the very foundation of preventive medicine—has been told to them by the news media for years and years, to little or no avail.

The increased cost of medical care is listed as one of the problems. This is evident to everybody. It is fussed about out of all proportion. And it is difficult to understand why. Medical care costs have not increased as much as have the costs of the postal service, Social Security, the federal government, and possibly certain projects under government control. As compared with all the advances in medicine, the cost of medical care probably is not inflated at all!

Mr. Schwartz thinks that most of the rise in medical care expense is directly due to and is the sole responsibility of the federal government. Increased demand created by the originators of Medicare and Medicaid with all the golden promises of care of the highest quality for everyone, is, in his opinion, the basic cause.

He likens the federal bureaucratic prescription, i.e., more government medicine to cure the price problem which was produced by the government, to the drunk who drinks whiskey to sober up.

Editorial Notes . . .

Persons with cancer of the large bowel are twice as likely to have had an appendectomy as the general population. The Texas M. D. Anderson Hospital and Tumor Institute is now conducting further research to determine the reason for the relationship. The appendix contains a large amount of lymphoid tissue which is concerned with immune defense against cancer. However, if this is the basis, it is a very special one since patients who have had a tonsillectomy do not have an increased incidence of bowel malignancy. The possibility that some persons are at high risk both for appendicitis and for bowel tumors is one of the possible answers.

Medical Newsletter of the Vanderburgh County Medical Society quotes some facts from Ronald Reagan that should be quoted again: "The president of Eli Lilly and Company said the drug firm spends more man-hours on government-related paperwork than they do today on heart and cancer research combined. They submitted one ton of paper, 120,000 pages of scientific data, most of which were absolutely worthless for the FDA's purposes, in triplicate, in order to get a license to market a particular arthritis medicine."

An Alcoholics Anonymous survey shows a nearly 50% increase since 1974 in the percentage of recovered alcoholics under 30 years of age. The study also revealed that 32% of the patients coming to AA today are women. Effectiveness of AA treatment is demonstrated by the fact that an alcoholic who tries the program for 90 days has a 50% chance of sobriety for one year—a one to five year loyalty to the program raises the prognosis to 80% and a member with over five years cooperation has a 90% chance of remaining sober and enjoying AA fellowship for another year.

All sports are becoming so popular, both with participants and with the public, that the seasons are getting longer and longer. This is fine except for the fact that sometimes the sport gets lengthened into a weather season that is unsuitable. Indiana high school team physicians are noticing the effects of football as played in an unseasonably hot September. Some say start football later and let it run into the cooler or even colder weather in late fall. This is difficult because it then overlaps football into the basketball months—and everyone knows what happens when you mess with basketball in Indiana. Quite a problem. No easy solutions. But it is something that should be studied.

CONTINUED ON PAGE 1109

The Great Laxative Escape



COLACE

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company, Evansville, Indiana 47624 U.S.A. 1578-1

COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows
Possibly Effective

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding

Parenteral administration is not recommended in the presence of hypotension or tachycardia

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

MeadJohnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4258

EDITORIALS

Editorial Notes . . .

CONTINUED FROM PAGE 1106

The Pharmaceutical Manufacturers Association has sued the State of New York because a state law mandates the dispensing and purchase of a different, lower-priced product even when pharmacist and patient prefer otherwise if the prescribing physician has not specifically forbidden substitution by writing on the Rx. New York has adopted a formulary which lists, as therapeutically equivalent, a long list of drugs which are chemically equivalent but have not been proven as therapeutically equivalent or have actually been proven to be non-therapeutically equivalent.

Upjohn research indicates that, in mice, injections of prostaglandins prevent the body from losing its ability to produce interferon as a natural defense against virus infection. Interferon also inhibits division of certain cancer cells and causes changes in other immune responses. Research will be conducted on humans.

If HEW Secretary Califano is cited for contempt of Congress because he has failed to reveal trade secrets that are protected by federal law, he will realize that he has had a difficult choice. The maximum penalty for contempt or for revealing secret information is the same—one year in jail. Surely Congressional action will not force him into such a paradoxical position. But, if it does, he may obtain whatever comfort he may from the fact that Congress gave him a choice of a year in jail for contempt or a year in jail for violating the trade secrecy law.

Public Affairs Pamphlet No. 558 is entitled "Health Hazard Appraisal: Clues for a Healthier Lifestyle." The theme of the booklet is: "Americans would be much healthier and safer if they quit smoking, cut back on drinking, watched their diets, used seat belts, relaxed and exercised." The author, Lydia Ratcliff, a health care planning writer, is a smart person. She knows that what America needs is more health education. The pamphlet is available for 50 cents by writing to Public Affairs Committee, 381 Park Avenue South, New York City, 10016.

Upjohn scientists have discovered a process for the artificial production of a potential anti-cancer substance that may be made by natural means, but which is difficult to produce in amounts sufficient for clinical trial. The substance is an antibiotic amino acid called AT-125. It is a natural product produced in the fermentation broth of streptomycete. In animal studies it has shown to be highly effective in lymphoid leukemia and lymphocytic leukemia as well as ovarian and breast cancer in mice. Clinical trials in humans will start soon.

Enough Canadian physicians are leaving Canada to create a worry for the government. The reasons for leaving are presumably and even obviously related to the Canadian Medicare system. Last year 733 doctors departed. In the first quarter of '78, 145 more went. One suggestion to slow the emigration is to, by law, require each physician to repay the cost of his or her medical education prior to leaving.

WHAT'S NEW?

IN BOOKS . . .

CONTINUED FROM PAGE 1100

book can be understood by young children if read to them by older siblings or adults. It is recommended to physicians, other health professionals, social workers and educators, in addition to patients and families. 203 pages—\$7.95.

* * *

An index of hidden medical diseases and conditions has been published in booklet form by Medic Alert Foundation International. It indexes 27 categories of conditions. It is classified according to International Classification of Diseases, Eighth Revision. Copies are available by writing the Foundation at P.O. Box 1009, Turlock, Calif. 95380.

* * *

Doubleday has published "The Pesticide Conspiracy" by Robert Van Den Bosch. He reports on the number and universality of pesticides and the possible and sometimes certain crises they cause. **Publishers Weekly** says: "A must for all people concerned about our environment and food supply." Pages—226, price \$8.95.

* * *

Doubleday has released "THE ANN LANDERS ENCYCLOPEDIA A TO Z/ Improve your Life Emotionally, Medically, Sexually, Socially, Spiritually." It is not a collection of her columns but a newly conceived work which includes 400 original articles, plus a few columns. Pages—1248. Price—\$17.50.

* * *

Guest Editorial

On Rights and Justice

L. A. ARATA, M.D.
Shelbyville

Because we are human beings, we all have certain rights not carefully defined or catalogued. The founders of our Nation claimed the right to freedom, life, liberty, and pursuit of happiness. We have some rights to property. Most would agree that we have rights to the necessities of life—food, shelter and clothing—and some would add medical care to that list.

Other items may be added to or deleted from the list by some people, although most would agree that all persons must have certain rights simply because they exist, and that at least some of their rights are enumerated above.

To help secure and maintain human rights, people have organized into societies of one kind or another: tribes, nations, cities, etc. Now, in our country as in many places on this earth, it seems that the very societies created to help preserve human and individual rights are systematically depriving people of their rights under the guise of preserving them. Such action is taking place in our own U.S.A.

Most of us have been deprived of our right to walk the streets at night; in some places, it is unsafe to drive the streets at night. We are being deprived of our property by attempts to limit our privilege of defending our property against theft and robbery by the attempt to deprive us of our means of defense under the guise of *gun control*.

We are being deprived of our rights to peaceful existence by the legal system that refuses to remove perpetrators of violent crime from our

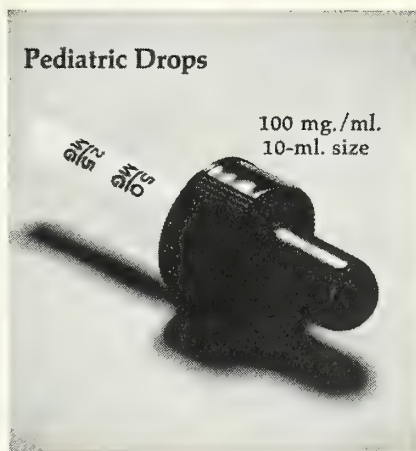
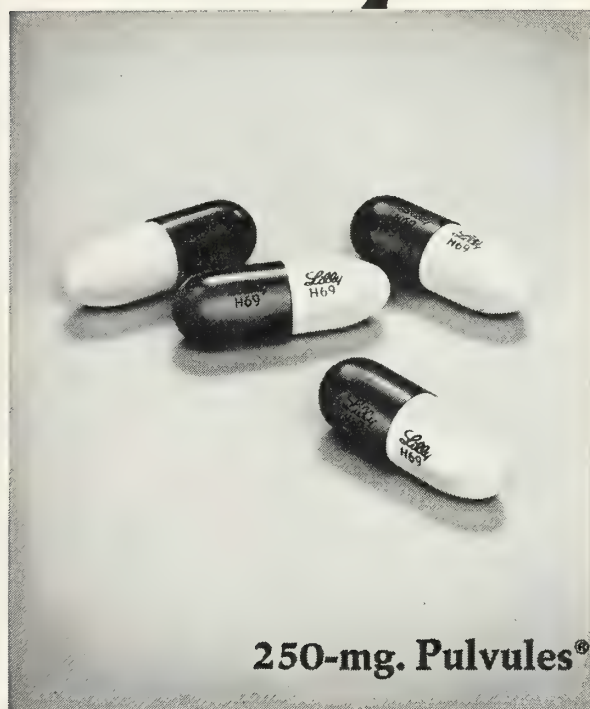
midst. The news media are replete with stories of crime being repeated by persons on parole, and by people awaiting trial for violent crime. We taxpayers are being deprived of our property by being forced to support in expensive prisons criminals who have known no life except violent crime—rather than eliminating them by capital punishment. In fact, it has gotten to the ridiculous point where it seems the only people whose rights are protected are the violent criminals.

Wherein lies an answer? I do not know, but I do feel that no society can long exist that fails so miserably to protect the rights of the majority of its people. It further seems that the biggest obstacle to the preservation of human rights in our U.S.A. is the court system. We would probably be better off if our entire system of courts and judges could be junked. Perhaps something better could be built from the ruins.

We hear the pious meaningless nothings spouted about “equal justice before the law;” “justice based on law;” and a system of “justice.” These are meaningless because the law is interpreted by the courts to mean what some judge somewhere says it means—and not what the laws say they mean.

In fact, we have *no* system of justice in our land. We have, instead, a legal system that has nothing to do with justice. We have courts of law all over the land; nowhere, it seems, is there a court of justice.

easy to take



Keflex®
cephalexin



500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206



AUXILIARY REPORT

Ruth (Mrs. G. Beach) Gattman
President, ISMA Auxiliary

Henry van Dyke, in his "Spirit of Christmas," expresses some sentiments that are especially appropriate at this time of year!

"It is a good thing to observe Christmas day. The mere marking of times and seasons, when men agree to stop work and make merry together, is a wise and wholesome custom. . . But there is a better thing than the observance of Christmas day, and that is keeping Christmas. Are you willing to forget what you have done for other people, and to remember what other people have done for you; to ignore what the world owes you, and to think what you owe the world; to put your rights in the background, and your duties in the middle distance, and your chances to do a little more

than your duty in the foreground; to see that your fellowmen are just as real as you are, and try to look behind their faces to their hearts hungry for joy; to own that probably the only good reason for your existence is not what you are going to get out of life, but what you are going to give to life; to close your book of complaints against the management of the universe, and look around you for a place where you can sow a few seeds of happiness—are you willing to do these things even for a day? Then you can keep Christmas."

May your home be filled with the joy, peace and love that is yours as you help keep Christmas, and may 1979 bring you much happiness in your service to others.

Guest Editorial

New President Pledges Support for Auxiliary

JAMES A. HARSHMAN, M.D.

President

Indiana State Medical Association

I would be remiss if, as one of my first actions as the new president of the Indiana State Medical Association, I failed to pledge my full support for our Auxiliary. At both the state and county levels, our Auxiliary, under the leadership of Mrs. Ruth Gattman, has shown that it is truly unified in its continuing efforts to assist the ISMA in advancing the causes of medicine and public health. It is my sincere desire, therefore, that our Auxiliary receive full support and cooperation from the ISMA membership at large.

The Auxiliary has worked with various ISMA commissions, providing valuable input to many of them along the way. Their advice and assistance in public relations, legislation and convention arrangements, for example, have been of tremendous assistance. Their Congressional letter-writing campaign, their fund drives on be-

half of the Indiana Medical Political Action Committee, their efforts in malpractice legislation, and their financial efforts on behalf of the AMA-ERF program have proven how a well organized and dedicated Auxiliary can support a professional organization.

Particularly noteworthy has been our Auxiliary's untiring efforts in the national immunization program. Just this year, Governor Bowen designated our Auxiliary as the Lead Voluntary Action Committee to coordinate all immunization activities in Indiana. But they haven't rested on their laurels. They are also involved in such health-related programs as child abuse, blood pressure clinics, skateboard safety, nutrition, C.P.R. and health fairs, to name but a few.

I praise the Auxiliary of the Indiana State Medical Association, extend season's greetings to each member and potential member, and trust that the Auxiliary will enjoy even more success in the new year.

**YOU'LL GET PROMPT
PROFESSIONAL RESULTS
WHEN YOU REFER A
HEARING-IMPAIRED
PATIENT TO A**

Beltone[®]

Hearing Aid Specialist

**IN INDIANA
YOUR INDEPENDENT AUTHORIZED DEALERS ARE:**

Wayne Ankenbruck
Beltone Hearing Aid Service
628 East Wayne
Ft. Wayne, Indiana 46802
(219) 422-9821

Gene Armel
Beltone Hearing Aid Center
322 W. Main
Madison, Indiana 47250
(812) 265-2365

Milton A. Brinza
Beltone Hearing Aid Center
809 Merchants Bank Building
Terre Haute, Indiana 47808
(812) 232-8172

D. W. Childers
Beltone Hearing Aid Center
1128 - 16th Street
Bedford, Indiana 47421
(812) 275-7498

Beltone Hearing Aid Center
220 South Walnut Street
Bloomington, Indiana 47441
(812) 334-3918

Kenneth L. Hoon
Beltone Hearing Aid Service
2039 East Main Street
Richmond, Indiana 47374
(317) 962-4332

Charlie P. Johnson
Beltone Hearing Aid Center
1827 - 25th Street
P.O. Box 341
Columbus, Indiana 47201
(812) 372-1886

Van L. Julian
Beltone Hearing Aid Service
2574 Charlestown Road
New Albany, Indiana 47150
(812) 945-0235

Earl S. McDaniel, Jr.
Beltone Hearing Instruments
2801 Lincoln Avenue
Evansville, Indiana 47714
(812) 479-1437

Beltone of Vincennes
Security Bank Building
20 North 3rd - Suite 338
Vincennes, Indiana 47591
(812) 882-4715

L. B. O'Connell
Beltone Hearing Aid Service
1906 East Main Street
Lafayette, Indiana 47901
(317) 447-6535

Anita Reid
Beltone Hearing Aid Service
1403 Brown Street
Anderson, Indiana 46016
(317) 643-3389

Beltone of New Castle
1936 South Memorial
New Castle, Indiana 47362
(317) 521-2970

Beltone of Muncie
1404 Granville Square
Muncie, Indiana 47362
(317) 288-8737

Beltone of Kokomo
404½ Arnold Court
Kokomo, Indiana 46901
(317) 453-1944

Beltone of Logansport
308 East Broadway
Logansport, Indiana 46947
(219) 753-3510

Beltone of Peru
51 South Broadway
Peru, Indiana 46970
(219) 472-1410

Tom Sotos
Beltone Hearing Aid Service
136 Sibley Street
Hammond, Indiana 46320
(219) 931-5272

Beltone Hearing Aid Service
4581 Broadway
Gary, Indiana 46409
(219) 884-4144

Stanley Thomas
Beltone Hearing Aid Service
724 W. Washington Avenue
South Bend, Indiana 46601
(219) 287-7221

Beltone Hearing Aid Service
401 West Marion
Elkhart, Indiana 46514
(219) 674-5957

G. A. Van Hoose
Beltone Hearing Aid Service
115 N. Pennsylvania Suite 1156
Indianapolis, Indiana 46204
(317) 632-3116

L. B. O'Connell
Beltone Hearing Aid Service
1906 East Main Street
Lafayette, Indiana 47901
(317) 447-6535

Beltone

WORLD LEADER IN HEARING AIDS AND HEARING TEST INSTRUMENTS

ELECTRONICS CORPORATION

4201 West Victoria Street • Chicago, Illinois 60646

An American Company



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article continues my discussion of the gift and estate tax sections of the Tax Reform Act of 1976 (TRA) and the proposed changes which are in the Technical Corrections Bill (TCA).

After a decedent has computed the amount of the estate tax payable (prior to any credits), the decedent is entitled, under section 2010, to subtract a new credit—the "unified credit"—against the result of the difference between the step one and step two estate tax computations. This new unified estate tax credit is in addition to the other credits which were (and still are) in the estate tax law, prior to the TRA, with one exception. The one exception is the credit (under section 2012) for gift taxes paid on lifetime transfers which are includable in the donor's gross estate, for estate tax purposes. This credit has been repealed as to gifts which are made after 1976. The new unified estate tax credit increases from \$30,000 for individuals who die during 1977 until, after other annual increases of approximately \$4,000 each, the credit reaches \$47,000 for individuals who die during 1981 or thereafter. Specifically, the unified estate tax credit schedule is as follows.

For Individuals Dying In	The Credit Is
1977	\$30,000
1978	34,000
1979	38,000
1980	42,500
1981 or thereafter	47,000

As stated above, the main purpose of the new unified estate tax credit is to treat persons who transfer small estates as favorably as persons who transfer large estate. This is, under the former law, if the effective estate tax rate on a decedent's taxable estate was, for example, 30%, then the former \$30,000 estate tax exemption (of section 2521) would have saved the decedent \$9,000 of estate taxes. On the other hand, if the effective estate tax rate on another decedent's estate was 40%, then the former \$30,000 estate tax exemption would have saved the latter decedent \$12,000 of estate taxes. However, the new unified estate tax credit saves each decedent the *same* amount of money.

There is one possible reduction of this

new unified estate tax credit. Section 2010(c) states that the allowable credit must be reduced by 20% of any portion of the former \$30,000 gift tax exemption which the decedent used for gifts made *after* September 8, 1976 and prior to 1977. That is, if a decedent used any part of the decedent's former \$30,000 gift tax exemption when the decedent made gifts during the period of September 9, 1976 through December 31, 1976, then the decedent will lose some of the unified estate tax credit which is available after 1976. Also, as discussed in the Gift Taxation part of this article, the decedent must reduce the decedent's unified *gift* tax credit by such use of the decedent's gift tax exemption during that period. Thus, for each year after 1976, a decedent who so used any or all of the decedent's gift tax exemption must reduce the decedent's unified gift tax credit for each year by the applicable 20%. If a decedent used any or all of the decedent's gift tax exemption *prior* to September 9, 1976, then the decedent will not reduce the decedent's new unified gift credit or unified estate tax credit for such pre-September 9, 1976 use. Unlike the unified gift tax credit, the unified estate tax credit is not reduced by prior uses of the unified gift tax credit, and, obviously, the unified estate tax credit is not reduced by prior uses of the unified estate tax credit.

To summarize, for individuals who die after 1976, there is a new unified estate tax credit, which may be used once (at the decedent's death) and which is fixed by law at certain amounts for each year. As to this credit, it increases each year, until 1981, at which time the credit is fixed at \$47,000. Further, while this credit is *increasing* each year, the credit will also be reduced each year by 20% of the amount of any use, by the decedent, of the decedent's \$30,000 gift tax exemption during the period of December 9, 1976 and before 1977. Of course, the unified estate tax credit is a non-refundable credit—due to section 2010(d).

At first glance, it appears that an individual may benefit from both the unified gift tax credit and the unified estate tax credit, that is, it appears that

both credits, in fact, may save the donor-decedent an amount of gift tax and estate tax up to the amount of each of the credits involved. However, mathematically, this is not true. That is, even though an individual may actually subtract the unified gift tax in computing the individual's gift tax due for a particular period and actually subtract the unified estate tax in computing the individual's estate tax due, nevertheless, the unified gift tax merely serves as a "pre-use" of the estate tax credit.

This latter point may be illustrated with two simple (and very general) examples. If an individual transfers all of the individual's funds as gifts (after 1976) and the gift tax on the transfers equals the applicable unified gift tax credit, then, at the individual's death, the individual's step one estate tax computation will compute a tax on the individual's taxable estate *alone* (because all of the gifts are includable in the individual's taxable estate under the three year rule of section 2035, and as a consequence, there will be no adjusted taxable gifts), or, the individual's step one estate tax computation will compute a tax on the individual's adjusted taxable gifts *alone* (because none of the gifts are includable in the individual's taxable estate under the three year rule of section 2035, and as a consequence, there will be no taxable estate). In either case, step one will (in theory, and assuming no changes in the values of the assets, etc.) produce the same tax. Then, step two of the estate tax computation will result in a zero tax (because the gift tax on such gifts would have been, in fact, zero). And, the tax which is computed in step one minus the zero tax of step two will result in an estate tax which will be eliminated by the unified estate tax credit. Thus, in such a case, the individual merely transferred the individual's funds during the individual's life, tax-free, instead of transferring the funds at death, tax-free.

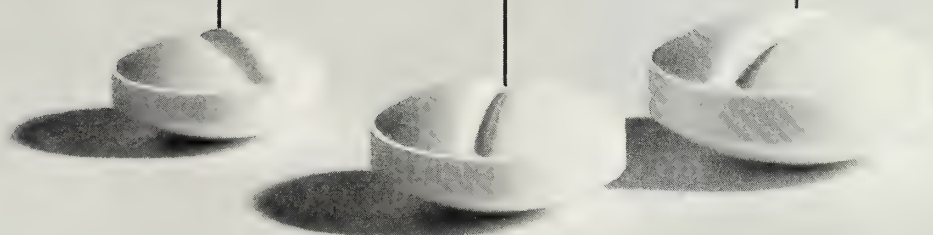
On the other hand, if the individual did not make any lifetime transfers, and transferred all of the individual's funds at death, then step one of the estate tax computation will result in the same step

CONTINUED ON PAGE 1119

100 mg

250 mg

500 mg



Tolinase[®] **tolazamide, Upjohn**

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

© 1977 THE UPJOHN COMPANY

CANCER CORNER

EVERY PHYSICIAN'S OFFICE—
A CANCER DETECTION CENTER

Breast Cancer

Over the past four years, some 280,000 American women have participated in a breast cancer screening program jointly sponsored by the National Cancer Institute and the American Cancer Society. More than 2,500 early breast cancers have been detected among these women in 27 projects; 45% were found by mammography alone. About 30% of the unsuspected tumors were detected in women between the ages of 35 and 50, and in that group mammography alone accounted for 40% of the diagnoses.

The risk for all American women for breast cancer is one in 13, or 7.69%.

A few epidemiologists have theorized that there might be a tiny additional risk of cancer from the minimal radiation (1 rad) used in project mammography examinations. Since a 1960s study had not shown a special benefit from mammography for women under 50—and although the risks of the exam have never been proven—an expert review committee, headed by Dr. Samuel Thier of the Yale School of Medicine, recently recommended to the NCI that the program be continued but that routine mammography be used only for women over 50, or for those younger women at high risk of developing breast cancer.

In the 40 to 49 age group, screening continues on women whose mothers or sisters have had breast cancer, or who have had the disease themselves. For women 35 to 39, the X-ray procedure is limited to those who have already had breast cancer. *No limitations were recommended for diagnostic mammography when there are symptoms of disease.*

Mammography Bulletin

A special pathology review committee of NIH recently checked slides of tissue of 506 tiny breast lesions, less than 1 cm. in diameter, discovered by mammography in Breast Cancer Detection Demonstration Projects. The committee thought that 66 lesions had been misdiagnosed—that they were benign.

Immediately, critics of the projects charged that needless mastectomies had been done. Confusion and fear spread among women nationwide about not only the supposed dangers, but also the inaccuracy, of mammography.

Now it has been revealed that the NIH committee did not see the original slides. Of the 66 "questionable" cases, *53 are now confirmed by the same committee as being cancer.* These patients had mastectomies, after careful evaluations. In 11 cases, there had

been disagreement between pathologists; *none of these women had had mastectomy.*

The reason for the wrong slides was that the hospitals had been reluctant to give the committee original slides, for medico-legal reasons. They made new slides from the same patient tissue for the review committee. Since lesions were so tiny, there was not enough malignant tissue for new slides. Hence, the experts saw only benign tissue, while believing they were reviewing original pathology slides.

Improved Survival Rates

Statistics compiled by the National Cancer Institute show that death rates for certain cancers are on the decline. Different types of cancer are more likely to afflict specific age groups. For types in age groups under 35, cancer death rates for the nation have dropped from 12 per 100,000 in 1950 to 8 in 1970.

For children under 15, the decrease (from 8 deaths to 5) is largely the result of advances in treatment of acute leukemia, and brain, kidney, and bone cancers. Too, a large majority of children with acute lymphocytic leukemia (ALL) now have access to the best available medical care.

In regional sampling of 101 new cases of ALL children under 15, the median time from the first symptom to seeing a doctor was one month. It took an additional week to first diagnosis, and just one more day to first treatment. Two-thirds of the children were alive two years later. The survival of these children is comparable with that in one of the best clinical cooperative groups.

In the 15 to 34 age group, decreased mortality rates (from 15 to 10) result largely from successful treatment for Hodgkin's disease and other lymphomas. In the 35 to 55 age range, the death rate remained constant at about 115. And above age 55, death rates have increased (from 609 to 674), probably because of new cases caused by cigarette smoking, industrial exposure and inadequate treatment.

Bladder Cancer and Saccharin

Experiments in which rats developed bladder cancer after having received huge doses of the artificial sweetener, saccharin, have given rise to epidemiological studies looking for an increase in the disease in man that might be related to saccharin use.

British and American studies of mortality rates from bladder cancer fail to show any increase attrib-

CONTINUED ON PAGE 1119

n pharyngitis and tonsillitis

...prompt temporary relief
of pain even before
patients leave
your office.

CĒPASTAT[®]

mouthwash/gargle/sore
throat lozenges

Merrell

Even Anesthetic Effectiveness

ing the throat with CĒPASTAT
soothing relief within minutes.
patients will appreciate this relief
waiting for therapeutic measures
hold. The well-established
anesthetic effects of CĒPASTAT pro-
soothing temporary anesthesia to
irritated or inflamed oropharyngeal
sa.

PASTAT in your treatment room . . .

as a spray, CĒPASTAT is more
to deliver the most relief to the
al area of the throat.

Suit the product to the patient . . .

The liquid is best for use at
home as a spray or gargle. Lozenges
are ideal for patients on the go.

A recommendation is best . . .


It costs less. Keeps the emphasis
where you want it . . . on more
important counter-measures — your
prescription for anti-infectives, for
example.

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



relief of minor
sore throat when
patients want it . . .

stat



Tagamet[®]

brand of

cimetidine

How Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).
Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
a SmithKline company

TAX TIPS

CONTINUED FROM PAGE 1114

one tax as would be computed in step one of the prior example (assuming no changes in the values of the assets, etc.), and, step two of the estate tax computation will still result in zero tax (because there were no lifetime gifts). And then, the tax computed in step one minus the zero tax of step two will result in an estate tax which will be eliminated by the unified estate tax credit.

Prior to the TRA, there were five credits against the estate tax, namely: the credit for state death taxes (section 2011); the credit for gift taxes (section 2012); the credit for taxes on prior transfers (section 2013); the credit for foreign death taxes (section 2014); and, the credit for death taxes on remainders. As stated above, the TRA added the unified estate tax credit (section 2010) and repealed (for post-1976 gifts) the credit for gift taxes. Further, the TRA amended sections 2011 through 2014 in order to

repeal the repeal of the estate tax exemption (section 2052) and the addition of the unified estate tax credit. Finally, section 2011 (concerning the state death tax credit) has been amended in order to limit the amount of the state death tax credit to the excess of: the estate tax imposed over the unified estate tax credit. Thus, the state death tax credit will not become a refundable credit.

Summary of Changes to Estate Tax Rates and Credits

Below is a brief statement of the changes which were made by the TRA and by the TCA to the estate tax rates and the estate tax credits. **The TRA:**

1. Replaced the former gift tax rates with a new unified (gift and estate tax) rate schedule;

2. Provided a new method for applying the new estate tax rates to the taxable base; and,

3. Provided a nonrefundable unified

estate tax credit;

4. Amended various estate tax credit sections in order to reflect the repeal of the estate tax exemption and the addition of the unified estate tax credit.

And, the TCA:

1. Provides certain estate tax adjustments for situations in which spouses elected to split gifts for gift tax purposes, which gifts are includable in the taxable estate of one of the spouses.

If you are looking for ways to be charitable this year, I would be grateful if you would send your "out-of-date" looseleaf tax services (for example: BNA; CCH; and P-H services) to me at 735 W. New York St., Indianapolis, Ind. 46202, so that I can pass them on to students who are particularly interested in studying and practicing tax law. If you would like to have one of the students pick up the services at your office, please call me at: (317) 264-4986.

CANCER CORNER

CONTINUED FROM PAGE 1116

uted to saccharin consumption. Further, diabetics in both countries experience no excess mortality from the disease, despite their high intake of saccharin.

Two American Health Foundation epidemiologists, Drs. Ernst Wynder and Robert Goldsmith, recently studied saccharin use in 146 patients with bladder cancer and in 132 matched cancer-free controls. They report that the risk of bladder cancer in male and female saccharin users was somewhat lower than in non-users.

In a study done by Dr. G.R. Howe and his colleagues in three Canadian provinces, 632 patients with bladder cancer were compared with local residents of the same age and sex. Significantly more male cancer patients reported having used saccharin than did controls. However, editors of the highly respected British journal, *THE LANCET*, where the study was published, warn that the conclusions drawn by the Canadians are based on "insufficient data" and are, therefore, "superficial". They call for further work on the subject.

Laetrile Proven Worthless

Dr. David P. Houchens, an immunologist, and Dr. Artemio A. Ovejera, an animal geneticist at the

Battelle Memorial Institute in Columbus, Ohio, report that Laetrile was of no benefit against human breast and colon cancers that had been grafted or transplanted to 108 "nude mice" born without a thymus gland, which normally plays a crucial role in the immunological defense system. The absence of the thymus gland allows transplanted human cancers to grow in the mice, because the animals do not reject the tumors.

Separate groups of mice with breast or colon cancer were injected every four days with three doses of Laetrile. Other mice with colon cancer were divided into groups and treated for nine days. One group received Laetrile only; another group just beta glucosidase, the enzyme supposed to trigger the release of cyanide from Laetrile; and still another group received a combination of drug and enzyme. After 42 days, there was no difference in tumor growth between mice that did or did not receive Laetrile.

The Battelle experiments are the latest in a series of National Cancer Institute studies begun in 1957 aimed at testing new substances and drugs for efficacy against cancer. None of these studies, done at seven major research centers, has shown Laetrile to have any effect on animal or transplanted human cancer.

Shallenberger's Secret? An Old-Time Approach

Crossing through a narrow hallway crammed with files, records and assorted medical supplies, Dr. Henry R. Shallenberger entered the office in his home.

A bald, bespectacled man, he was dressed professionally in blue slacks, shirt and tie. He looks, even at 75, like a doctor.

His office, however, is not the type of room typical of many in his profession. The door leading to the hallway is thickly covered with photographs of children, most of whom he delivered.

Medicine bottles and knick-knacks clutter his old wooden desk. Notebook papers from his grandchildren, scrawled carefully with Bible verses, adorn the white walls.

Shallenberger finds no embarrassment in being referred to as a country doctor. He prefers rural practice. That's why he has stayed in Modoc for 40 years and has never considered moving anywhere else.

The community honored his long years of service with an open house at the Union School cafetorium in May.

Dr. Shallenberger chuckles that he tries to keep his place of business "from looking like a doctor's office, and some of my patients say I've succeeded."

An examining couch near the desk gives the only indication of the room's purpose.

Like other older doctors, he does not admire the techniques of younger physicians, with their emphasis on specialization and a barrage of what he believes are often needless tests.

"I remember a patient several years ago who had bad tonsils," he recalled. "She was a lady in her 40s or 50s. I told her she needed her tonsils out."

But her family, he added, didn't want to take the advice of a country doctor. They sent her to a clinic but the doctors there could not, even after extensive testing, discover her ailment; they never looked at her tonsils.

The woman finally returned to Dr. Shallenberger. "We took her tonsils out and she got better," he laughed.

That particular episode illustrates another criticism he has about modern medical practice. "So many doctors don't pay any attention to patients anymore . . . don't speak to them."

In his office, there are no appointments. Patients are free to come in on Mondays from 1 to 4 p.m., and Tuesdays, Wednesdays, Fridays and Saturdays from 1 to 4 and 7 to 9 p.m. Shallenberger works nights and weekends in addition to answering house calls, which average three or four a week—occasionally at an odd hour.

And he doesn't take mornings off. Those are spent at the Henry County Hospital, where he is a staff physician and assists in surgery. "I suppose I average 10 patients daily down there," he said.

"The secret of my success," he confided, "is I get a lot of patients nobody else will have."

Those patients include 100 nursing home residents in New Castle and persons on welfare and Medicaid.

His prices tend to be more affordable than most. He charges between \$6 and \$10 for an average office visit and has recently delivered babies for about \$120.

"The state welfare department wrote me a letter once telling me I was not charging enough," he reported.

For a high school dropout who began work in the Pennsylvania coal mines at the age of 13, it's a satisfying life.

Before deciding upon the medical profession, Dr. Shallenberger worked in everything from banking to plumbing. His reasons for becoming a doctor were not exactly inspired by any lofty desires to aid the human race.

"I was going with a nurse one time," he remembered. "I was madly in love. She wanted to marry a doctor."

Thus began his study of medicine. It didn't help his love life, however. The nurse eventually married a railroad fireman.

Reprinted with permission from the PALLADIUM-ITEM, Richmond, Ind. Original article by Linda Bloom. Photo by PALLADIUM-ITEM.

"So many doctors don't pay any attention to patients anymore . . ."

After completing his degree at the University of Pittsburgh in 1933, Dr. Shallenberger and his wife, Gertrude, moved to Union Deposit and later to nearby Hershey, Pa., at the urging of a fraternity brother in the area. They soon moved and spent the winter of 1935-36 in Rabbit Hash, Ky., across the Ohio River from Rising Sun, Ind.

His next stop, Grayson, Ky., was even further into the hill country. The roads, graded by Works Progress Administration labor, had no gravel. "I would drive for miles down there in mud, just like you push through snowdrifts here," he said.

Dr. Shallenberger took to riding horses, but found that wasn't much easier because of the steep hills. "You had to hold onto the horse's neck going up and the tail going down to keep from falling off," he laughed.

Going to Modoc in 1938 was a change for Shallenberger, and he says he has always been happy with his practice there. He bought their present house, which has since been enlarged, from another doctor for \$2,000.

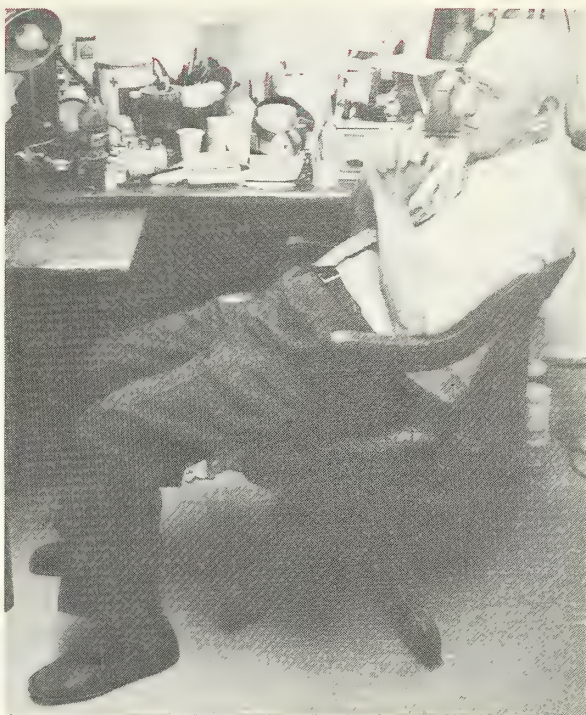
Being a doctor's wife in a small community was a little hard for Mrs. Shallenberger. She believes many people were afraid to be too friendly to her because of her position. In the same way, she added, the three children were always seen as "the doctor's children."

Although she has tried several times to interest the doctor in taking a job somewhere else, Gertrude Shallenberger does not regret the time spent here. "We've had a very good life," she declared. "The children have had, if not everything they wanted, everything they needed."

Their daughter Christine, her husband and her two daughters, Betsy and Becky White, now live in Winter Haven, Fla. The couple's son, Hugh, is a psychologist and assistant to the state hospital superintendent in Fulton, Mo., and the father of two children, Hugh IV and Jenny. Daughter Penny resides in Fairland, Ind. Her two children are Hank and Mamie Yost.

Only Judy Williams, their adopted daughter, and her two boys, Tim and Stacy, still live in the Modoc area.

Occasionally, the doctor went to extremes to please his children—once to his wife's horror. "He shaved his head 22 years ago because Penny was in love with Yul Brenner," she remembered, adding she nearly fainted the day he came into the kitchen and took his hat off to show her. He has been shaving his head every day since that time.



"Actually, I got tired of going to the barber shop every 10 days," Dr. Shallenberger said. "It's so much more convenient than having hair."

He begins his daily routine by rising at 3:40 each morning and shaving his head in bed. Then he stands on his head for about five minutes, something he has been doing for 10 or 15 years.

"It's good exercise. I used to jump rope every morning, but my wife complained about shaking the house," he said.

He has breakfast, does some paperwork and perhaps makes a house call before he leaves for the New Castle hospital around 6:45 a.m. If the weather is nice, he tries to spend an hour in the garden just after daybreak.

"I've never seen the time he's had a complete day off unless we're on vacation," his wife declared. Nonetheless, she usually manages to get him to their favorite restaurant, in Hagerstown, a night or two each week.

Even after 44 years of medical practice, Dr. Shallenberger has shown few signs of slowing down, somewhat to his wife's dismay. But she concedes retirement will not come until he is forced into it, despite occasional rumors floating around town.

He finds some humor in these rumors. "Who said I was going to retire?" he asked a recent caller. "That's the first time I heard about it."

He wore an amused expression after ending the conversation. "This lady wants to see me one more time before I retire," he laughed, as if the very idea were absurd.

Getting Involved

From The Journal 50 Years Ago

ISN'T it about time for physicians to get over the idea that it is beneath their dignity to have anything to do with politics or legislation affecting their interests? They are quite willing to let someone else do the work for them, but most of them are unwilling to turn a hand to help themselves even when necessary for their own salvation. The time has arrived when physicians will have to take some hand in shaping legislation that affects them or they are going to be wiped out as independent practitioners. What is being done to destroy the independence of the medical man also is injurious to the public, but the public is being fed up by a lot of high pressure salesmanship on the part of members of the pseudomedical cults and medical pretenders, to say nothing of the specious pleas of welfare workers of one kind or another who have false Utopian ideas concerning some kind of free medical and surgical services for all. At our legislative sessions there are representatives of all those who are antagonistic to the progress of scientific medicine and the welfare of regular medical practitioners. Oftentimes these representatives are the paid representatives who

are on the job constantly to look out for the interests of their employers. Medical men look to a healthy public sentiment to swing the pendulum in their direction, but the odds are against them. Oftentimes it is better to fight your enemies with their own weapons and then go them one better in the scrimmage. We must lay aside all prejudice against labor in our own behalf, and throw aside the halo of professional dignity insofar as it pertains to objections to employing lobbyists or their equivalent to represent us in the law-making halls. During the session of the Indiana legislature we ought to have a paid, able and shrewd representative on the ground every minute to represent us when any problem presents, and at all times to work intelligently and effectually in the interests of medical progress and the economic standing of medical men in general. Such a man should be secured for the coming session of our legislature, an all-time man, and if his salary cannot be paid from the treasury of the Indiana State Medical Association, then pass the hat and raise the money.

JISMA, December 1928

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Southern Indiana Office: Kenneth W. Moeller, Representative
1810 Broad Ripple Avenue Telephone: (317) 255-6525
Mailing Address: P.O. Box 20132, Indianapolis 46220
Northern Indiana Office: Douglas O. Sellon, Representative
120 LaSalle West Bldg., Suite 304
South Bend, In. 46601 Telephone: (219) 289-7332

Surgeon Found Not Negligent

In a malpractice action against an orthopedic surgeon, an Indiana appellate court ruled that a trial court acted properly in giving and refusing instructions to the jury.

The orthopedic surgeon treated the patient for various fractures and other injuries received in an auto accident. The jury decided in favor of the surgeon, and the patient appealed.

The patient objected to a jury instruction that it was proper for a physician to use any recognized method of treatment if more than one method was recognized among physicians and surgeons of ordinary skill. The court found that this was a correct statement of the law.

The patient also objected to instructions as to the applicability of the locality rule in assigning the standard of care. He said that the instructions referred to a physician and not to an orthopedic surgeon. The court pointed out that an additional instruction that the surgeon was required to possess the degree of skill and knowledge ordinarily possessed by physicians specializing in orthopedics provided the jury with the proper standards with which to test the surgeon's actions.

The patient contended that instructions on the locality rule were in error because no evidence was presented on the rule. The court said that although this was true, where the instruction was probably not the basis for the verdict, such error was harmless.

As to a contention that the surgeon, being a specialist, was not protected by the locality rule, the court pointed out that the state Supreme Court had approved an instruction applying a modified locality rule to specialists and that the instruction given was a correct statement of the law.

Finally, the court refused to instruct the jury that the surgeon was negligent if he was aware of and customarily employed an accepted method of treatment but did not use the method in treating the patient. Pointing out that the physician could choose any method of treatment approved and accepted by the profession, the court found that the instruction was properly refused as an incorrect statement of the law and affirmed the lower court's judgment.—*Joy vs. Chau*, 377 N.E. 2d 670 (Ind. Ct. of App., June 28, 1978)

Reprinted courtesy of THE CITATION, AMA, Oct. 1, 1978.



Forget Everything you ever knew about borrowing Money

Introducing a new loan: **THE PROFESSIONAL**

so unique that we have over \$4,000,000.00 in personal loans made to Physicians and Dentists.

Unique Features...

- **PAY ANY AMOUNT ANY DAY OF THE MONTH.**

In good times, pay more. During slow periods, pay the minimum.

- **WE MAKE HOUSE CALLS.**

A collect call is all that's necessary to begin processing your loan. We will come to your home, office or hospital to close your loan at your convenience.

This confidential loan is made for any good purpose . . . long term or short . . . \$10,000 to \$50,000. An interest-bearing loan, it can be repaid in varying amounts and on any day. You pay only for the time you use the money. Call today.

PROFESSIONAL LOAN DIVISION

Ask for Colin G. Haza
Assistant Vice President
110 East Washington Street
Indianapolis, Indiana 46204
Phone (317) 631-1311

Indianapolis

**Morris
Plan**

ANCEF[®]
brand of sterile
CEFAZOLIN SODIUM
GETS TO THE SITE



**OF SERIOUS
RESPIRATORY INFECTIONS**

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported:
Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred.
Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported.
Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

**ANCEF®
IV
IM**
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

FUTURE FILE

CME Congress in Illinois

The Illinois Council on Continuing Medical Education will sponsor a Congress on CME April 6-7 at the Oak Brook Hyatt House, Oak Brook, Ill. Its theme relates to the basics of CME program planning: Planning a CME Program That Works; What to Present; Checking for Effectiveness.

For information, write to the ICCME at 55 E. Monroe St., Suite 3510, Chicago 60603.

Journey to the Orient

A journey to five Far East countries next June for the study of oriental health care will be sponsored by Brevard Community College of Florida. Allied health and nursing professionals will visit Japan, Hong Kong, People's Republic of China, South Korea and Taiwan to observe health education, facilities, treatments, delivery systems and services. Approximate cost is \$2,000. Departure date will be June 9. For information, write Dr. Corinne B. Linton, 1519 Clearlake Road, Cocoa, Fla. 32922.

Michigan CME Offerings

The following courses are sponsored by the University of Michigan Medical School and meet criteria for Category 1 credit. For further information, contact the university's Department of Postgraduate Medicine and Health Professions Education, The Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48109.

Jan. 18-20: Rheumatology, for rheumatologists, internists and family physicians;

Feb. 4-9: Family Practice Update, for family physicians;

Feb. 15: Continuing Pathology, for pathologists;

Feb. 19-23: Emergency Medicine, for family physicians, internists and emergency physicians;

Feb. 27-28: Topics in Psychosomatic and Behavioral Medicine, for psychiatrists and primary care physicians.

Pediatric Dermatology Seminar

The sixth annual Pediatric Dermatology Seminar will be held in Darwin's Galapagos Islands, Feb. 17-25, aboard the M/V Buccaneer, a luxury ship. Daily lectures and discussions will be led by Dr. Guinter Kahn of Miami Beach.

For more information about the seminar, contact Dr. Kahn at 16800 N.W. 2nd Ave., No. Miami Beach, Fla. 33169.

University of Texas CME Course

"Radiology of the Acutely Ill and Injured Patient" will be presented Jan. 26-27 in Houston by the Department of Radiology and the Health Science Center of the University of Texas Medical School. The course meets the criteria for 14 credit hours in Category 1 of the AMA's Physician's Recognition Award.

Contact the Division of Continuing Education, University of Texas Health Science Center at Houston, P.O. Box 20367, Houston, Tex. 77025.

Indiana University CME Courses

Jan. 15-17: Cross-Sectional Echocardiography Workshop (Indianapolis);

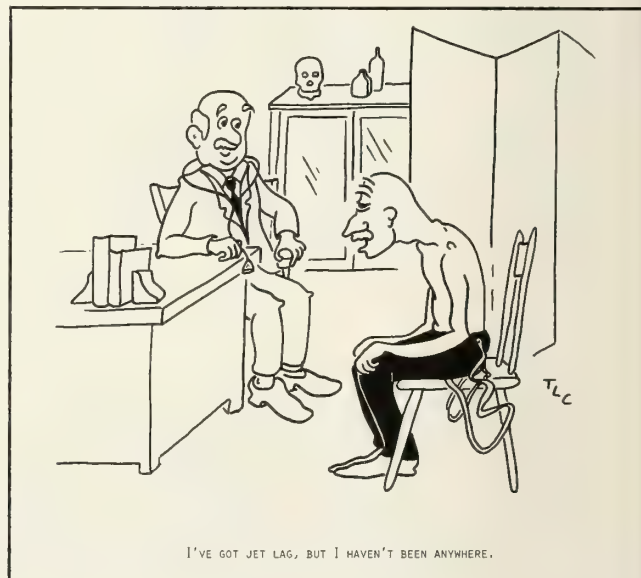
Feb. 7-8: Coronary Artery Disease (Indianapolis);

Feb. 15: Medical Emergencies (Richmond).

For information, write or call the Indiana University School of Medicine, Division of Postgraduate Medical Education, 1100 W. Michigan St., Indianapolis 46202. Tel: (317) 264-8353.

Hair Transplant Symposium

The annual hair transplant symposium and workshop will be held in Hot Springs, Ark., Jan. 25-27, 1979. It is sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, Inc., and endorsed by the American Society for Dermatologic Surgery. Registration fee is \$720. For further information, contact Dr. D. B. Stough, III, Program Director, Doctors Park, Hot Springs, Ark. 71901.




DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When
impotence
is due to androgenic deficiency.

 **Android**[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. / mg. / mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Technologist There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

There are several kinds of techs found in a hospital today; laboratory and x-ray technologists come to mind immediately. The respiratory and operating room techs still call themselves *technicians*, but this name will probably evolve into *technologists*, too. And this evolution appears to be a good thing.

The word *technician* is used more frequently than *technologist*, but many people don't like being called

technicians. Somehow the idea of a *mindless technician* is present—I don't know where this started, but it exists. And rightly or wrongly, many techs feel "put down" when they're called *technicians*.

Techne is the Greek stem that means *hand skill* primarily; the *ology* suffix means *the study of*. And these stem meanings are carried along when one uses the word, *technologist*.

This word implies more knowledge and application of that knowledge to the job at hand, then *technician* does. *Technologist* implies that the person is an ongoing student—still learning—rather than approaching his work with a mind that is closed.

Let's call them *techs* for short, but *technologists* when we need the full title.

Public Attitude Survey

79% of Hoosiers Support Deductibles

Seventy nine per cent of Hoosiers would favor having a deductible on their health insurance coverage and most want mandatory coverage of catastrophic health care, according to a public attitude survey released last month by the Indiana Hospital Association.

The degree of support for health insurance deductibles was an unexpected finding in a survey conducted by Selection Research, Inc.

"Although the deductible is always under discussion as a way to emphasize cost awareness in the purchase of health care, we did not expect the degree of support this alternative had among the Hoosier public," said Elton TeKolste, president of IHA. "Given the choice, the public would apparently prefer to pay some of their smaller health care bills and have insurance cover the eventuality they may have a large catastrophic bill," he said.

Respondents supported several other changes in health care financing. Eighty-six per cent favor requiring employers to provide basic health insur-

ance; 66% favor mandatory coverage of catastrophic medical expenses provided either by government or employers; and 55% said they would support having government provide health insurance coverage for the unemployed.

Virtually all those interviewed (93%) said they had a hospital close enough to serve their needs. Most people (83%) said the hospitals in their area serve their health care needs effectively. Eighty per cent said they opposed reducing the number of beds in hospitals.

The IHA also asked the public's opinion on national health insurance, and found that 41% now favor a national health insurance scheme, while 48% oppose it and 12% are undecided. Low income, younger individuals were more prone to favor national health insurance. Even so, 37% of the total respondents believed the quality of health care would be lower under NHI, while 40% said it would remain the same and 17% thought it would improve.

THE JOURNAL, in cooperation with the Division of Postgraduate and Continuing Medical Education of the Indiana University School of Medicine, offers its readers a Continuing Medical Education program. This is the 12th in a series of CME articles, produced by the faculty of the School of Medicine and is supported by a grant from its Division of Postgraduate and Continuing Medical Education.

As an organization accredited for continuing medical education, the Indiana University School of Medicine certifies that this continuing medical education activity meets the criteria for 1 credit hour in Category I for the Physician Recognition Award of the American Medical Association provided it is used and completed as designed.

To obtain Category I credit, complete the quiz on Page 1149.



Why Some Infants Fail to Thrive: A Problem With Serious Implications

**During infancy regular weight gain is perhaps
the best indicator of normal nutrition and health . . .**

MORRIS GREEN, M.D.
Indianapolis

FAILURE TO THRIVE and gain weight or actual loss of weight is a symptom with serious implications in infants. During early infancy, weight gain is relatively rapid, amounting to 5 or 6 and sometimes up to 10 ounces a week. In the latter half of the first year the gain is slower, 3 to 5 ounces a week.

During the first year of life, infants should demonstrate a steady weight gain. Failure to do so calls for a careful investigation. During infancy regular weight gain is perhaps the best indicator of normal nutrition and health. Periodic assessment and recording of an infant's weight and length is an ex-

The author is Lesh Professor and Chairman, Department of Pediatrics, Indiana University School of Medicine.

cellent, simple screening tool. *As a general rule, if an infant fails to gain on a formula that is quantitatively and qualitatively correct, there is something wrong with the infant or the feeding situation and not with the formula.* Alterations in the formula or changing to other preparations will usually not correct this problem.

There are a finite number of causes for an infant not to thrive, and a systematic, diagnostic approach will reveal the cause in almost every instance. The etiologic classification given below is based on the clinical experience at the Riley Hospital for Children.¹

QUALITATIVE OR QUANTITATIVE INADEQUACY OF FOOD INTAKE:

A. Inadequate intake.

B. Anorexia due to organic or psychologic factors.

C. Feeding difficulties due to organic factors.

- Congenital anomalies, e.g., glossoptosis or cleft palate.

- Dyspnea, e.g., due to congenital heart disease, causes difficulty in feeding.

- Infants and children who are developmentally retarded may feed poorly, and, therefore, fail to thrive.

D. Calorically inadequate formula.

E. Breast-fed babies may fail to gain adequately because of an inadequate supply of breast milk. Although some of these infants will appear hungry, others will not cry excessively.

DEFECTS IN ASSIMILATION OF FOOD:

A. Inadequate digestion.

- Cystic fibrosis. Failure to gain in spite of hunger and a large food intake is an early symptom of this disease.

- The syndrome of pancreatic insufficiency and neutropenia may

be characterized by failure to thrive.

B. Inadequate intestinal absorption.

- Celiac syndrome.

- Gluten-induced enteropathy.

Failure to thrive is not an early symptom in patients with celiac disease. Vomiting and perhaps diarrhea may occur first, followed by irregular weight gain. Loss of weight does, of course, become a prominent manifestation in children with untreated celiac disease.

- Giardiasis.

- Gastrointestinal allergy.

- Tuberculosis of mesenteric nodes.

- Biliary atresia.

C. Systemic infections may interfere with normal assimilation. Congenital viral infections, such as cytomegalio virus or rubella, are frequently characterized by failure to thrive.

D. Protein-losing gastroenteropathy.

E. Hirschsprung's disease.

LOSS OF FOOD SUBSTANCES:

A. Persistent regurgitation or vomiting.²

- Gastroesophageal reflux may lead to regurgitation that is severe enough to cause an abnormally slow weight gain or a weight loss.

- Rumination, the regurgitation of previously swallowed food, usually begins between the third and sixth months of age. These babies can lose significant amounts of weight. The etiology is a problem in the maternal-infant interaction.

B. Persistent diarrhea.³

- Disaccharide intolerance.

FAILURE OF UTILIZATION OR INCREASED METABOLISM:

A. Excessive crying or activity; restlessness.

B. Prolonged fever.

C. Repeated acute or chronic infections.

- Prenatal viral infections.

- Repeated respiratory infections.

- Tuberculosis.

- Intestinal parasites.

- Histoplasmosis.

- Urinary tract infections.

- Sepsis in newborn infants, especially prematures, may be primarily characterized by failure to thrive. Poor feeding, loss of vigor, regurgitation and irritability may be associated symptoms.

D. The possibility of a malignancy should always be kept in mind in the child with a history of weight loss or unexplained listlessness.

E. Cardiac disorders. Failure to gain may be the first indication of cardiac disease in infants. As long as an infant with congenital heart disease gains weight normally, his arterial oxygen saturation is not reduced to a critical level. Failure to gain may be an early symptom of endocardial fibroelastosis and of impending congestive heart failure, especially in infants with ventricular septal defects. Difficulty in feeding and poor weight gain may be the first manifestations of cardiac failure.

F. Determination of the blood pressure is important in infants who are not thriving. Early symptoms in infants with coarctation of the aorta may be anorexia, vomiting, tiring during feedings and failure to gain weight adequately.

G. Chronic pulmonary disease; hypoxia. A roentgenogram of the chest is indicated in infants who fail to thrive.

H. Renal disease.

- Chronic renal insufficiency and metabolic acidosis.

- Renal tubular acidosis (idiopathic renal acidosis, hyperchloremic acidosis with nephrocalcinosis) is characterized by a hyperchloremic acidosis. The distal form of RTA (type 1) is characterized by urine with a pH greater than 6 regardless of the degree of acidosis.

The proximal form (type 2) demonstrates normal acidification of the urine with a pH less than 5. Type 1 renal acidosis may be characterized by vomiting, anorexia, constipation, polyuria, polydipsia, dehydration, hypotonia and failure to gain weight in infants between the fourth and sixth months of life. Type 2 RTA causes growth failure and vomiting but otherwise such patients are asymptomatic.

- Other types of renal disease such as chronic pyelonephritis, chronic glomerulonephritis, hydronephrosis or polycystic disease of the kidneys may lead to failure to thrive. Failure to gain and to grow is probably the most common presenting complaint in infants with serious anomalies of the urinary tract.

I. Idiopathic hypercalcemia of infancy. This disorder is characterized biochemically by hypercalcemia and clinically by anorexia, vomiting, constipation, failure to thrive, irritability, thirst, fever, hypotonia and muscle weakness.

J. Hepatic insufficiency.

K. Bartter's syndrome causes severe failure to thrive in the early months of life. Clinical manifestations include vomiting, constipation, hypokalemia, hypochloremia and at times, hypomagnesemia.

L. Chronic anemia.

M. Endocrine disorders.

- Hypothyroidism. Infants and children with hypothyroidism do not thrive well. Part of this is attributable to the feeding problems due to difficulty in sucking and swallowing and to lethargy. Failure to thrive may be the first clinical indication of congenital hypothyroidism.

- Diabetes. Rapid loss of weight and dehydration and acidosis may be early manifestations of this disease.

N. Storage diseases.⁴

- Lysosomal storage diseases,

including Gaucher's disease, Wolman's disease and mucopolysaccharidoses.

- Mucopolidoses.

O. Inborn errors of metabolism may present with poor feeding and failure to thrive.^{5,6}

- Galactosemia. Infants with this disorder may demonstrate jaundice during the neonatal period. Failure to thrive is an early symptom, associated, at times, with vomiting and diarrhea. The liver becomes enlarged. Galactosemia and albuminuria occur. Cataracts and mental retardation may develop if the disease has been unrecognized for some time. Urine may be screened easily for galactose by finding a positive Clinitest reaction in the presence of a negative Tes-tape or Clinistix test.

- The de Toni-Fanconi Syndrome is characterized by hypophosphatemia, renal hyperaminoaciduria, organic aciduria and renal glycosuria. Hyperchloremic acidosis, hypokalemia, polyuria and albuminuria may be associated findings. Cystinosis, a recessive, inherited disorder, is the most common cause of the Fanconi syndrome in infancy and early childhood. Failure to thrive is an early finding in these infants. Polydipsia, lassitude and muscle weakness may be present.

- Kinky hair disease.

- Hypophosphatasia. Failure to thrive may occur in the first six months of life in these patients along with anorexia, irritability, vomiting, fever and convulsions.

- Hereditary fructose intolerance. With young children, clinical manifestations include failure to thrive, persistent vomiting, hypoglycemia, and hepatosplenomegaly.

- Homocystinuria.

- Almost all the other inborn errors of metabolism are characterized by failure to thrive if the baby does not die in the immedi-

ate newborn period. Often there are accompanying symptoms and findings, including jaundice, hepatomegaly, intractable metabolic acidosis, ketosis, dehydration, anorexia, lethargy, vomiting, diarrhea, convulsions, coma, abnormal urine odor, abnormal hair, unusual facies and macroglossia. The specific diagnosis requires laboratory studies such as urine for metabolic genetic screening, including examination for organic acids.

P. Miscellaneous.

- Chondrodystrophia calcificans congenita. Most of these patients fail to thrive; some of the babies develop normally.

- Fetal alcohol syndrome.⁷

- Chromosome abnormalities.

NEUROLOGIC AND PSYCHOLOGIC:

A. Lack of good parenting care and an absence of environmental stimulation may contribute to poor growth during infancy.

B. Infants with cerebral damage, mental retardation or cerebral palsy often do not thrive. Because of feeding difficulties, their caloric intake is often less than that of normal children.

C. Diencephalic syndrome.⁸ This syndrome, reported in association with intracranial neoplasms in the region of the hypothalamus and third ventricle in infants and children under 2 years of age, is characterized by a paradoxical alertness, euphoria and hyperactivity in the presence of emaciation. The appetite is normal or increased. Vomiting may occur irregularly. The usual signs of intracranial hypertension are absent. Other findings may include pallor, nystagmus and tremor.

D. Infants whose failure to thrive is associated with maternal deprivation may have an inadequate caloric intake either because they are not offered sufficient food or because they do not eat it if offered. This is

the most common cause of failure to thrive.^{9,10,11}

General Approach to Failure to Thrive: The pediatric interview and the physical examination are of preeminent importance in the initial appraisal of failure to thrive. If the initial impression suggests a psychosocial or environmental etiology, a period of observation in the hospital with a normal diet and developmentally appropriate nursing care will soon be confirmatory. The baby will gain weight rapidly and achieve impressive developmental progress. Most babies with failure to thrive are in this group. If this does not appear to be the etiology, selected laboratory procedures may be obtained including CBC, urinalysis, serum electrolytes, calcium, BUN, creatinine, and T4, T3. Other studies, e.g., urine for genetic

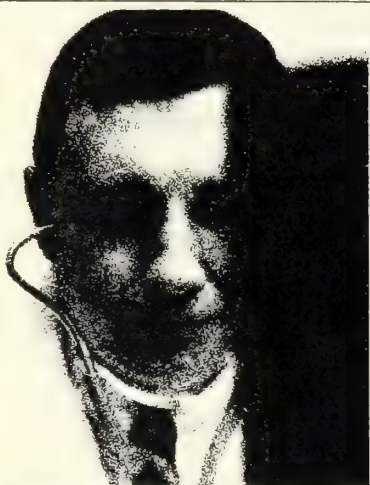
screening, bone age, skull films, sweat chloride and serum carotene, may be obtained as appears clinically indicated.

REFERENCES

1. Green, M: Failure to thrive. In Green, M: *Pediatric Diagnosis*. Interpretation of Signs and Symptoms in Different Age Periods. Philadelphia. W. B. Saunders Co. Third edition. To be published 1979.
2. Fitzgerald JF: Vomiting. In Green, M and Haggerty, RJ: *Ambulatory Pediatrics II*. Philadelphia. W. B. Saunders Co. 1977, Chapter 7, p. 110.
3. Fitzgerald, JF: Diarrhea. In Green, M and Haggerty, RJ: *Ambulatory Pediatrics II*. Philadelphia. W. B. Saunders Co. 1977, Chapter 8, p. 113.
4. Beaudet, AL: Genetic diagnostic studies for mental retardation. *Current Problems in Pediatrics* 8:3, March 1978.
5. Burton, BK and Nadler, HL: Clinical diagnosis of the inborn errors of

metabolism in the neonatal period. *Pediatrics* 61:398, 1978.

6. Nyhan, WL: Approach to the diagnosis of overwhelming metabolic disease in early infancy. *Current Problems in Pediatrics* 7:3, April 1977.
7. Handon, JW, Jones, KL and Smith: Fetal alcohol syndrome. *JAMA* 235:1458, 1976.
8. Burr, IM, Slonim, AE, Danish, RK, Godoth, N and Butler, II: Diencephalic syndrome revisited. *J Pediat.* 88:439, 1976.
9. Fischhoff, J, Whitten, CF and Pettit, MG: A psychiatric study of mothers of infants with growth failure secondary to maternal deprivation. *J. Pediat.* 79:209, 1971.
10. Leonard, MF, Rhymes, JP and Solnit, AJ: Failure to thrive in infants. *Am. J. Dis. Child.* 111:600, 1966.
11. Whitten, CF, Pettit, MG and Fischhoff, J: Evidence that growth failure from maternal deprivation is secondary to underfeeding. *JAMA* 209: 1675, 1969.



MALPRACTICE INSURANCE AVAILABLE

**Owned by
PHYSICIANS**

**Operated by
PHYSICIANS**

**For the protection of
PHYSICIANS**

R&SLI

Physicians & Surgeons Liability Insurance Co., Inc.
800 Mac Arthur Boulevard / Munster, Indiana 46321
219 836-2288

RENOVASCULAR HYPERTENSION:

How to Make the Diagnosis in Your Office

Hypertension X

Testing for stenosis of renal arteries can usually be performed on an outpatient basis . . .

CLARENCE E. GRIM, M.D.
Indianapolis

THE MOST COMMON surgically curable cause of hypertension is that due to stenosis of one or both renal arteries. The true prevalence of this disease in the general hypertensive population is not known. Although the only certain way to make this diagnosis is by arteriography, a recent analysis of our experience at the Indiana University Medical Center Specialized Center of Research (SCOR) in Hypertension suggests that the tests needed to make this diagnosis 95% of the time can be easily performed on an outpatient basis. (*See Table*)

From the Specialized Center of Research (SCOR) in Hypertension, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

RENAL ARTERY BRUITS

Listening for bruits caused by turbulent blood flow through the stenotic area of the renal artery(s) is the simplest technique available. In our experience, this office examination alone will allow you to detect about one-third of the patients with renal artery stenosis. The important feature to listen for is a bruit with both a systolic *and* diastolic component. This single finding is essentially pathognomonic of renal artery stenosis.

I have found that this is best done in a quiet room. Fans and blowers in the background can make this bruit hard to hear. The patient is examined while lying supine with the knees flexed. The stethoscope is placed lightly on the epigastrium and bruits are listened for intently. The quality and pitch of diastolic component of the bruit is very similar to that of a soft aortic insufficiency murmur. Next, exert pressure on the head of the stethoscope and push down over the aorta. Listen carefully for a bruit that is both

systolic and diastolic. If nothing is heard in the center of the epigastrium, move the head of the stethoscope in all directions and listen in each area for an elusive bruit. Do not be afraid to exert firm pressure. It is very difficult to cause a bruit with a diastolic component by pushing too hard.

Occasionally, the bruit will only be present after inspiration or expiration. When you have satisfied yourself whether there are any significant bruits in the epigastrium, have the patient sit while you listen over the back directly over the spine from T-12 to L-2. Finally, listen along the lower aspect of the rib cage from the spine around each flank. As you listen remember that the portion of the bruit that is of most importance from a diagnostic point of view is that sound which extends into diastole. In my experience an epigastric or flank bruit with a diastolic component is always abnormal. In hypertensive patients 95% of these bruits will be due to renal artery stenosis whereas 5% will be caused by obstruction

of the celiac axis or superior mesenteric artery. In either case, abnormal bruits with diastolic components are indicative of vascular disease.

THE INTRAVENOUS PYELOGRAM

The second screening test available to the practitioner is the minute sequence or hypertensive intravenous pyelogram. This should detect 75% of the patients with renovascular hypertension. There are three things to look for with this test:

- A difference in size between the two kidneys (right 2 cm. smaller than the left or the left 1.5 cm. smaller than the right);
- A delay of one-minute or more in the appearance of dye in the calyces of the affected side; and
- Later hyperconcentration of dye by the affected kidney.

The presence of *any* of these in a hypertensive patient should lead the practitioner to consider renal angiography. I believe that any patient who has onset of hypertension at age 40 years or less, has a sudden onset of hypertension at any age or who has severe hypertension should have a hypertensive IVP. In our experience 84% of patients with renovascular hypertension will have *either* a diastolic bruit or an abnormal IVP.

PERIPHERAL PLASMA RENIN ACTIVITY

The third screening test available to the practitioner is the measurement of plasma renin activity which *may* be elevated in renal vascular hypertension. However, before this is measured, the factors that affect the level of renin must be carefully controlled.

A major determinant of plasma renin activity is the amount of sodium in the diet. Before obtaining a renin level for the evaluation of a high value the subject should not be

TABLE
Outpatient Findings in Renovascular Hypertension

1. Systolic-Diastolic Abdominal Bruit in 30%.
2. Abnormal Intravenous Pyelogram in 75%.
3. Increased Plasma Renin Activity in 33%.

eating a low sodium diet. To document this a 24-hour urine should be collected the day before the renin is obtained.

Many drugs will either increase or decrease renin levels. Therefore, all drugs should be stopped for at least two weeks. Renin levels are increased by standing, but tend to decrease in the afternoon. Therefore, to minimize these effects renin should be obtained in the morning (by 10 a.m.) after the patient has walked or stood quietly for two hours. You must choose a laboratory that can provide values from normal controls and tell you what their values have been in patients with proven renal artery stenosis. In our experience about 33% of patients with renal artery stenosis will have an increased peripheral renin level. On the other hand, the presence of a low renin level, in our experience, effectively excludes the diagnosis of renal vascular hypertension.

If you listen for a bruit, perform an IVP and measure a two-hour upright plasma renin level, then you should be able to detect 95% of the patients with renovascular hypertension who should have subsequent renal arteriography. On the other hand, if your patient does not have abnormal results for *any* of these tests, then you can be 99.5% certain that the patient does not have renovascular hypertension.

RENAL ANGIOGRAPHY AND RENAL VEIN RENIN SAMPLING

If the patient is an operative

candidate, renal angiography should be performed. This should be done by experienced personnel and selective views of each renal arterial system should be obtained. At Indiana University we have seen few complications from more than 800 transfemoral renal angiographies. None has resulted in loss of life or limb in the last seven years. However, we do not do this procedure on an outpatient basis.

If renal angiography shows a stenosis, then the following question needs to be answered: Is this stenosis causing the patient's hypertension? The most reliable way to answer this question is to perform renin measurements from the venous drainage of each kidney.

We believe renal arteriography should be performed before renal vein renin measurements since, in a patient with stenosis of a segmental branch of a renal artery supplying one portion of a kidney, it is important to attempt to obtain blood from the venous drainage of that ischemic portion of the kidney, and the arteriogram is necessary to provide a clue regarding the need for segmental renin sampling. Because of minute-to-minute changes in renin release from the kidney, the renal veins should be catheterized and sampled at the same time. This can only be done by having a catheter in each renal vein.

Proper preparation of the patient for renal vein renin sampling requires that the patient be salt-depleted before the samples are obtained.¹ Again the algorithm that we have previously described^{2,3} provides a standardized way to insure that this is properly performed in all patients.

Since the decision to operate hinges, in part, on the results of the renal vein renin measurements, you must have a reliable laboratory to which you send the samples. An in-

crease of renin 1.5 times greater in the renal vein draining the stenosed renal artery is the criterion that we believe must be satisfied. We believe that surgery should be performed only if you see a significant difference in renin levels.

TREATMENT OF RENOVASCULAR HYPERTENSION: MEDICAL OR SURGICAL

There are no randomized trials that answer the question: Should patients with renovascular hypertension be treated medically or surgically? Limited observations suggest that surgery is preferable, even if blood pressure can be controlled medically. Newer drug combinations, especially propranolol (Inderal) and hydralazine (Apre-soline) make it easier to control the blood pressure in patients with renovascular hypertension. However, the progressive nature of some types of renovascular stenotic disease makes it necessary to consider whether operative repair may in the long run be the preferred method of treatment since reduction of blood pressure alone has not been demonstrated to induce regression of the renal arterial lesion or prevent progression of renal impairment.

The strongest argument for operative rather than medical treatment comes from the experience of the Mayo Clinic, in a long term fol-

low-up of 214 patients.⁴ All were initially treated medically. One-half of these could not be well controlled and were then treated by unilateral nephrectomy or renal artery bypass surgery. By the end of nine years of follow-up, 60% of the patients managed medically had died, but only 30% of those treated surgically had died. Their conclusion is that perhaps most patients should be treated surgically.

This assumes, of course, that you have access to an experienced surgical team. Renal artery reconstructive surgery is a technically difficult procedure and, we believe, should only be performed by teams with considerable experience. Our team at the Indiana University Medical Center has had a large experience over the last seven years. Our most recent experience is currently being analyzed. In brief, more than 82 patients have had operative treatment here since 1970. Their age ranged from 3 to 70 years. A cure of the hypertension after one year was evident in 41% of these patients. An additional 54% were considered improved in that their blood pressure is now easily controlled on drugs. No change in blood pressure was seen in 3%. Two patients (3%) died following surgery, one had a pulmonary embolus on the day of discharge, and another patient died of intestinal obstruction and gram negative sepsis. Thus our 96%

cured-or-improved rate is as good or better than that of other Centers around the country.

SUMMARY

The diagnosis of renovascular hypertension can be suspected in the outpatient setting by listening carefully for abdominal bruits, performing an IVP and measuring a peripheral plasma renin level. If any of these findings are positive, hospitalization should be considered for arteriography and renal vein renin measurements. Referral to a Center with experience in these procedures and operative management of renal artery stenosis is the next step. The Specialized Center of Research in Hypertension at Indiana University School of Medicine is nationally recognized as such a Center and stands ready to aid you in the management of these problems.

BIBLIOGRAPHY

1. Melman, A, Donohue, JP, Weinberger, MH, Grim, CE: Improved diagnostic accuracy of renal venous renin ratios with stimulation of renin release. *J. Urology*, 117:145-149, 1977.
2. Grim, CE, Weinberger, MH, Higgins, JT, Kramer, NJ: Diagnosis of secondary forms of hypertension. *JAMA*, 237:1331-1335, 1977.
3. Grim, CE, Weinberger, MH, Higgins, JT: Evaluation of patients for secondary hypertension. *Comprehensive Therapy*, 3:8-11, 1977.
4. Hunt, JC, Strong, CG: Renovascular hypertension: Mechanisms, natural history, treatment. *Am. J. Cardiol.*, 32:562-574, 1973.

INDIANA MEDICAL BUREAU

1010 East 86th St.—72 Winterton

Indianapolis 46240

844-7933

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 26th Year of Service

NICOTINE ADDICTION: Treatment with Medical Hypnosis

PART 2

**Under hypnosis, patients were taught to relax
and to use auto-suggestions to maintain
abstinence from smoking . . .**

HANUS J. GROSZ, M.D.
Indianapolis

IN PART 1 of this series on the medical uses of hypnosis (*JISMA*, 71: 11, 1074-1075, November 1978), I reported the results, after three months of treating nicotine addiction with a single individual hypnotherapy session. This paper, Part 2, reports the results, also after three months, of treating nicotine-addicted patients with a single session of hypnotherapy administered in small groups.

From the Institute of Psychiatric Research, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46223.

Acknowledgement: The assistance of Steve Bojrab, freshman medical student at I.U. School of Medicine, who helped in the follow-up study, and Phyllis Bramer, research assistant, is appreciated.

SUBJECTS

The subjects are 141 self-referred cigarette smokers who requested treatment of their nicotine addiction by means of hypnosis. They were offered, and accepted, a single session of group hypnosis treatment. As with individual treatment, they were advised before registering for an appointment that there was no assurance that the treatment would be successful.

Fifty-one, or 36% of the subjects were men. Their mean age was 39. The 90 subjects (64%) who were women ranged in age from 15 to 64, with a mean age of 40. Both the men and the women started smoking on the average when they were between 17 and 18 years old. They were smoking on the average, between 30 and 35 cigarettes a day.

TREATMENT

The treatment was limited to a single session of about 90 minutes. It was conducted in groups of six to 12 subjects seated with the therapist in a circle.

The outline of the treatment program is summarized in *Table 1*. After the therapist and the patients were introduced to one another, the

therapist and the patients participated in a review of conditioned smoking patterns and in a discussion of the health hazards of smoking and of smoking as an addictive behavior.

Induction of hypnosis was preceded by comments about the nature of the hypnotic state to dispel unwarranted fears and common misunderstandings about hypnosis. Hypnosis was induced through progressive relaxation techniques, challenges and reinforcements. Once a satisfactory level of hypnosis was induced, suggestions were given, one, to strengthen the patients' determination to quit smoking; two, to create in the patients aversion to smoking with indifference to the smoking by others; three, to reduce the patients' craving for cigarette smoking; and, four, to desensitize the patients to external and internal stimuli triggering their smoking behavior. Finally, the subjects were taught self-relaxation and how to use auto-suggestions to maintain abstinence from smoking. They were given an opportunity to apply these techniques before departing.

RESULTS

Effectiveness of the treatment

was evaluated through a follow-up study conducted over the phone by a medical student on a summer fellowship. Successful treatment was defined as total abstinence from cigarette smoking for three months after treatment. Any smoking whatsoever, even if done only intermittently, was rated a treatment failure.

By these criteria, 58, or 41.1%, of the patients were treated successfully and 83, or 58.9%, unsuccessfully.

The results three months after treatment obtained with a single group hypnotherapy session do not differ significantly ($p > .37$) from the 43.8% success rate obtained with a single session of individual hypnotherapy.

DISCUSSION

Our study indicates that, after a follow-up period of three months, a single session of group hypnosis was about as effective in the treatment of nicotine addiction as was a single session of individual hypnotherapy. This does not mean that some patients would not respond better when seen individually or that others would not respond better when seen in a group.

Individual treatment offers the

advantage of greater privacy, a closer attention to the patient's own needs, a better opportunity for an in-depth exploration of the patient's symptoms, fears and psychodynamics, and a more personalized approach to the induction of hypnosis and to the hypnotherapy itself. Moreover, in the course of treatment, individual sessions are more likely to uncover both related and unrelated emotional problems for which the patient had been seeking counseling, but indirectly and under pretext of wishing to quit smoking.

Group hypnotherapy has certain advantages over individual treatment. It is, first of all, less costly. Secondly, though the patient feels more exposed when treated in a group, he also feels, at the same time, less threatened and less vulnerable. There is safety in numbers and the presence of others in the same predicament and about to undergo the same treatment is both supportive and reassuring. In the group setting, patients share with one another their experiences, symptoms, anxieties and fears and can exercise on one another constructive peer influences. These beneficial influences can carry over well after the treatment when the group is attended by couples,

friends or co-workers.

One of the more interesting features of the group treatment is the seeming tendency for the groups as a whole either to respond very well or very poorly. I have noticed that this is mostly the case where the groups are composed of patients who have made arrangements to come for treatment together. In some instances, the success rate was close to 100%; in others, close to zero. Since the distribution seems far from random, it would appear that in a homogeneous group, one or two influential patients with markedly strong positive or negative attitudes can make all the difference to the success rate of the group as a whole. In the same vein, the very treatment process in the session itself can be favorably or unfavorably influenced by the behaviors of one or two patients. This is one reason why the hypnosis treatment of patients in groups is, by and large, more demanding of the skills of the therapist than is individual hypnotherapy. The factors that seem to influence the successful treatment of nicotine addiction with individual and group hypnosis treatment will be discussed in more detail in a subsequent paper.

TABLE 1

Outline of a one session group hypnosis program for the treatment of nicotine addiction

1. Pre-treatment

- a. Introduction of therapist and group members.
- b. Review of patients' smoking histories and smoking patterns.
- c. Discussion of smoking as addictive behavior and of the health hazards of smoking.

2. Treatment

- a. Questions and answers concerning medical hypnosis.
- b. Group induction of hypnosis.
- c. Suggestions and instructions to hypnotized subjects.
- d. Termination of hypnotic state.

3. Post-treatment

- a. Questions and answers about treatment experience.
- b. Self-hypnosis and autosuggestions.

SUMMARY

The paper compares the results after three months of treating 141 cigarette smokers with a single session of hypnosis administered to groups of six to 12 patients with results that had been obtained after the same interval of time in the treatment of cigarette smokers with a single individual hypnotherapy session. The success rate, defined as total abstinence from smoking, of 41.1% for the single group treatment session did not differ significantly from the earlier reported success rate of 43.8% for a single session of individual hypnotherapy.

ABSTRACT

Twenty-four patients with pulmonary tuberculosis receiving steroids had undergone resective surgery from 1961 to 1965 at the Veterans Administration Hospital in Hines, Illinois.

These 24 cases were a part of a controlled study conducted at Hines to determine whether the addition of steroids in an adequate chemotherapeutic regime for extensive far-advanced pulmonary tuberculosis would have certain advantage over chemotherapy alone. Of 237 patients randomized in this study, 121 were in the steroid group and 116 served as controls.

Six of the 12 patients in the control group required pneumonectomy and only one of the 12 cases in the steroid group needed pneumonectomy. There were about twice as many lobectomies in the steroid group as in the Control.

This small series seems to suggest that the steroids may have a tissue-sparing effect in extensive far advanced pulmonary tuberculosis resulting in more limited pulmonary resection.

FELIPE S. CHUA, M.D.
JAMES R. ZVETINA, M.D.
T. K. RAGHUNATH, M.D.
WILLIAM E. NEVILLE, M.D.
ROQUE PIFARRE, M.D.
Hines, Illinois

Surgical Experience With Pulmonary Tuberculosis Patients Receiving Steroids

From the Cardiopulmonary Surgery Section of the Veterans Administration Hospital, Hines, Illinois and the Department of Surgery, Loyola University Stritch School of Medicine, Maywood, Illinois. Publication supported in part by a grant from INTERMEDICS INC., Freeport, Texas.

Dr. Chua is now in clinical practice of Thoracic & Cardiovascular Surgery in Lake County, Indiana.

Send reprint requests to Dr. Chua at 1830 Mirmar Road, Munster, Ind. 46321.

SINCE CORTICOSTEROIDS were introduced, numerous studies have demonstrated their effects on infectious disease processes by their interference with the normally occurring antigen-antibody phenomenon and reduction of the body's inflammatory response to the infection.¹

The dissemination of tuberculosis in animals and man receiving corticosteroid therapy alone or along with ineffective antimicrobial therapy has been well documented.^{2,3} However, the administration of corticosteroids to patients with active tuberculosis, who are being treated with effective antimicrobial drugs, has been shown to be safe and has

been often used advantageously in specific manifestation of tuberculosis.^{4,5,6,7,8,9}

A preliminary report of our controlled study of prednisone as an adjunct to the treatment of far-advanced cavitary pulmonary tuberculosis published in 1966 demonstrated that in certain proportions of the steroid treated group, there was more rapid roentgenographic improvement maintained over an extended period, earlier cavity closure, and lesser amount of residual lesion after prolonged chemotherapy.¹⁰ There was no significant advantage, however, in the attainment of bacterial conversion.

Of particular interest and requiring additional evaluation was the question of whether the addition of steroids may have a tissue-sparing effect, principally from the viewpoint of promoting more limited surgical resection in cases with initially extensive and widespread disease as compared to a control group.

The purpose of this paper is to present the results of our experience of this study in the patient who ultimately required pulmonary resection as observed at the Veterans Administration Hospital, Hines, Illinois.

MATERIAL AND METHODS

This study, initiated late in 1959 and terminated at the end of 1963, represented an extension of a protocol originally designed as one of the cooperative studies of the Veterans Administration and Armed Forces. Admission was limited to original treatment cases of far-advanced, cavitary, bacteriologically-proved pulmonary tuberculosis. Chemotherapy included 1 gram of streptomycin and 12 mg. isoniazid per kilogram body weight plus 100 mg. of pyridoxine daily for six months. Patients were assigned by

TABLE 3
Extent of Disease
(by N.T.A. classification)

GROUP	INITIAL		IMMEDIATELY PRE-OP.	
	Far Advanced	Mod. Advanced	Far Advanced	Mod. Advanced
Control	12	0	8	4
Steroid	12	0	6	6

random allocation to the steroid group or as controls. Prednisone, 30 mg. daily in three divided doses, was given for 90 days followed by a two-to-three week period of gradual tapering. Corticotrophin, zinc ACTH 40 units, was given intramuscularly on alternate days

a mean age of 41.4 years (*Table 1*).

There were five Caucasians and seven Negroes in the control, and three Caucasians, eight Negroes and one other in the steroid group.

Ninety-two per cent of the control and steroid patients respectively had multiple cavities initially. Cavitation was bilateral in five patients in the control and in three patients in the steroid group.

In the control group, there were two whose cavities were between 2 and 3.9 cm.; five between 4.0 and 5.9 cm.; and six with 6 cm. or more.

The principal consideration for surgical treatment was the persistence of cavitation where the pulmonary lesion was fairly localized with large caseous residual and destroyed lung. Another factor considered in the decision to recommend surgery was a history of one or two bacterial relapses, which occurred in six patients. Five of the 24 patients continued to excrete tubercle bacilli in their sputum one to three months prior to operation. Chemotherapy prior to surgery consisted of isoniazid, usually in combination with streptomycin or para-aminosalicylic acid, or both. The duration of the preoperative chemotherapy ranged from 6.5 to 9.5 months in 12 patients, and from 10 to 18.5 months in the remaining 12 patients, with an average of 10.2 months in the controls and 12.0 months in the steroids. Secondary drugs often employed at the time of surgery included one or two of the following: Ethionamide, viomycin, pyrazinamide and cycloserine.

Two patients in the steroid group

TABLE 1
Age Distribution

Total Number Observed: 24		
AGES	NUMBER OF PATIENTS	
	Control	Steroid
20 - 29	1	0
30 - 39	7	7
40 - 49	3	3
50 - 59	1	2
TOTAL	12	12

during prednisone therapy and for two weeks after the last prednisone.

The material randomized consisted of 237* patients who were found acceptable for the study, of whom 121 were in the steroid group and 116 served as controls.

A total of 24 patients in this study had undergone resective surgical procedure in the period between 1961 to 1965. Twelve patients were in the control and steroid groups respectively.

All patients were men and they ranged in age from 28 to 55 years in the control group with a mean age of 37.4 years, and from 34 to 54 years in the steroid group with

*There were 38 additional patients originally entered but they had to be excluded because of failure to meet one or more of the basic criteria for case selection.

TABLE 4
Surgical Complications

TYPE	NUMBER OF PATIENTS	
	Control	Steroid
Bronchopleural Fistula	1	1
Intrapleural Bleeding-decortication	0	1
Cardiopulmonary Insufficiency	1	0
TOTAL	2	2

did not complete the six-month treatment period as designed by the original protocol. One temporarily interrupted his treatment at the end of the fourth month and in the other, steroid therapy was discontinued after one month because of development of a diabetic state.

Only 37 of the 237 patients in this study were considered for resection and evaluated by the medi-

TABLE 2
Surgical Procedures

TYPE	NUMBER OF PROCEDURES	
	Control	Steroid
Lobectomy	4	9
Lobectomy plus	2	2
Pneumonectomy	6	1
TOTAL	12	12

cal-surgical chest conference. This relatively small percentage of cases presented for evaluation was attributed to either the fact that the majority of the patients were unsuitable for surgery because of the extent of residual disease present or that adequate results were obtained from medical treatment alone. Twenty-seven patients were initially recommended for excisional surgery but three refused.

In the control group resection was performed between 6.5 and 13.5 months in 10, and 31 months in two.

In the steroid group, pulmonary surgery was done between 7 and 10 months in eight patients; between 15.5 and 17 months in three; and 41 months in one patient.

RESULTS

CONTROL GROUP: In 12 patients in the control group, pneumonectomy was required in six patients. Lobectomy plus segmentectomy was carried out in two patients. Lobectomy was performed in four patients.

STEROID GROUP: In the 12 patients in this group, pneumonectomy was performed in only one patient. Lobectomy plus segmentectomy was carried out in two patients. Lobectomy was performed in nine patients.

The type and extent of the procedure are summarized in *Table 2*. Extent of the disease initially and immediately pre-op is shown in *Table 3*. Major postoperative complications occurred in four patients (*Table 4*, two in each group).

In the control series, one patient who underwent a pneumonectomy developed cardiopulmonary insufficiency and died on the eighth postoperative day. One other patient

TABLE 5
Duration of Follow-up
(Postoperative)

YEARS	NUMBER OF PATIENTS	
	Control	Steroid
Less than 1	2	0
1 to 2	3	2
2 to 3	2	0
3 to 4	4	4
4 to 5	1	4
Five or over	0	2
TOTAL	12	12

developed a bronchopleural fistula following pneumonectomy and expired 19.5 months later of complications, although he remained bacteriologically negative.

In the steroid series, one bronchopleural fistula followed a lobectomy and segmentectomy. The patient continued to improve, the pleural pocket decreased in size, and the sputum remained negative. One patient required early reoperation and decortication for intrapleural bleeding following a lobectomy.

Of the 12 patients in the steroid group, two received additional hormonal therapy during pre and postoperative period. It was not given in the remaining 10 patients and no complications were reported.

Of the 22 patients who survived, all had achieved an inactive status and had a postoperative follow-up ranging from 8 months to over 5 years, with an average of 36 months (*Table 5*).

One patient died 23 months following resection from a cause unrelated to his mycobacterial disease.

DISCUSSION

Of the patients who had undergone resectional surgery, pneumonectomy was judged as indicated in six instances in the 12 patients of the control group, whereas pneumonectomy was thought to be necessary for removal of the residual disease in only one of the 12 patients of the steroid group. This difference was attributed to the fact that there was probably more extensive disease remaining in the controls and this was further suggested by the fact that there were almost twice as many lobectomies in the steroid group as in the control group.

This surgical experience with cases of pulmonary tuberculosis

who have received steroids may be favorable, as compared with reports by others.

Johnson *et al* reported 52% of steroid therapy in his study had resections in contrast to only 32% of the placebo patients. He attributed this to the steroid therapy since his patients were proposed for surgery without knowledge of this group. He concluded that more rapid roentgenographic improvement in the steroid treated patients was responsible for the increased incidence of resection because this left a localized case of venous disease as an indication for surgical intervention at 6 and 8 months when the sputum had been recently positive for tubercle bacilli.¹¹

In a report from the Research Committee of the British Tuberculosis Association in 1961, it was disclosed that of all resectional procedures carried out in this study, a greater number of segmental resections were accomplished in the ACTH prednisone patients than in the control cases.¹²

The foremost indication for corticosteroids in tuberculosis treatment is for a patient whose life is threatened and will permit survival for sufficient time to allow the chemotherapy to become effective.^{13,14,15} Another use of steroids is to rapidly desensitize patients who had hypersensitivity to antituberculous drugs. Conflicting reports of benefit from corticosteroids have been reported in tuberculous pleural effusions, pericarditis, and meningitis.¹⁶ The present study and others would suggest that corticosteroids used concurrently with effective chemotherapy might be advantageous for that small group of far-advanced cavitory pulmonary tuberculosis patients presenting difficult therapeutic problems that ultimately may require surgical intervention, if one were able to predetermine this group initially.^{17,18}

SUMMARY

A controlled study was conducted to determine whether the addition of steroids to an adequate chemotherapeutic regime for extensive far-advanced pulmonary tuberculosis would have a certain advantage over chemotherapy alone. Of 237 patients randomized, 121 were in the steroid group and 116 served as controls. This report deals only with the 24 patients who, in this study, had undergone resective surgical procedures between 1961 and 1965. Twelve patients were in the control and steroid group respectively. Emphasis was placed on whether the addition of steroids may have a tissue-sparing effect principally from the viewpoint of promoting more limited resection.

Of particular interest was the fact that pneumonectomy was required in six patients in the control group and only in one in the steroid group. There were almost twice as many lobectomies in the steroid group as in the control group. There were four major complications following surgery. Average postoperative follow-up was 36 months. All of the surviving patients have achieved an inactive status.

REFERENCES

1. Kass, EH and Finland, M: The role of adrenal steroids in infection and immunity. *New England J. Med.*, 244:464, 1951.
2. Ebert, RH: In vivo observations on the effect of cortisone on experimental tuberculosis using the rabbit ear chamber technique. *Am. Rev. Tuberc.*, 65:64, 1952.
3. American Trudeau Society: The effects of cortisone or corticotrophin on human tuberculous infection: A statement prepared by the Committee on Therapy. *Am. Rev. Tuberc.*, 66:254, 1952.
4. Des Autels, EJ, Zvetina, JR, Berg, GS, Ferthing, J, and Freeman, J: The effects of corticotrophin (ACTH) and cortisone in fifteen cases of pulmonary tuberculosis. *Dis. Chest.* 30:486, 1956.

5. Johnson, JR, Turk, TL, and MacDonald, FM: Corticosteroid in pulmonary tuberculosis. *Am. Rev. of Resp. Dis.*, 96:43-73, 1967.
6. Weinstein, JJ, and Koler, JJ: Adrenocorticosteroid in the treatment of tuberculosis. *New Eng. J. Med.*, 260:412, 1959.
7. De Alemquer, M: Traitement de la tuberculose pulmonaire en articulo mortis par las cortisone associee aux antibiotiques: Communication preliminaire. *Acta Tuberc. Scand.*, 31: 356, 1955.
8. Houghton, LE: Combined corticotrophin therapy and chemotherapy in pulmonary tuberculosis. *Lancet*, 1:595, 1954.
9. Even, R, Sors, C, Troome, Y, and Sarrazin, A: Le traitement des pleuresies sero-fibrineuses tuberculeuses par L'ACTH, *Bull. Soc. Med. Hop. Paris*, 70:137, 1954.
10. Reisner, D, Zvetina, JR, Cohn, L: Adrenal steroids as an adjunct to the chemotherapy of pulmonary tuberculosis. *Am. Rev. Resp. Dis.*, 94:496, 1966.
11. Johnson, JA, Taylor, BC, Morrissey, JF, Jenne, JW, and MacDonald, FM: Overall results in Madison-Minnesota Veterans Administration Hospital steroid study. *Am. Rev. Resp. Dis.*, 92:376, 1965.
12. British Tuberculosis Association Research Committee: A trial of corticotrophin and prednisolone with chemotherapy in pulmonary tuberculosis. *Tubercle*, 42:391, 1961.
13. Turiaf, J, Marland, P, and Lockhart, A: Tuberculose pulmonaire et cortisone. *Rev. Tuberc. (Par.)*, 18:774, 1954.
14. Miller, AB: Use of steroids in tuberculosis. *M. Sc.*, 3:585-590, 1958.
15. Elsbach, P, and Edsall, JR: ACTH and cortisone as adjuncts in the treatment of advanced pulmonary tuberculosis. *Ann. Int. Med.*, 46:332-341, 1956.
16. Favez, G, and Aguet, F: Les indications de l'hydrocortisone et de la prednisone dans le traitement de la tuberculose pulmonaire evolutive. *Schweiz. Med. Wschr.*, 86:843, 1956.
17. Angel, JH, Chu, LS, and Lyons, HA: Corticotrophin in the treatment of tuberculosis. *Archives of Int. Med.*, 108:353, 1961.
18. Cochran, JB, Hislop, JA, and Clayson, C: Cortisone and chemotherapy in pulmonary tuberculosis. *Brit. J. Tuberc.*, 50:269-276, 1956.

Heel Ulcer Development and Successful Arterial Reconstructive Surgery

RONALD T. ROLLEY, M.D.
Lafayette

Heel pressure problems during and after successful arterial reconstruction can lead to heel ulcers . . .

THE DEVELOPMENT of heel decubiti in ischemic feet is a widely appreciated potential problem for which diligent prevention is usually practiced. However, heel ulcers also can develop secondary to heel pressure intraoperatively or postoperatively in cases of successful arterial reconstructive surgery. Such heel ulcers developed in nine patients at a 1,000-bed teaching hospital over a five-year period. The cases are reported to herald the need for attention to heel pressure problems during and after successful arterial reconstruction.

From the Department of Surgery, Arnett Clinic, 2600 Greenbush St., Lafayette, Ind. 47902.

CASE REPORTS

Case #1. A 63-year-old, white diabetic male requiring 30 units NPH insulin daily was admitted because of severe rest pain and superficial gangrenous ulcers of the left foot. Preoperative arteriography indicated an intact arterial tree through the left popliteal artery, but all three trifurcation vessels were occluded with the left anterior tibial artery reconstituted.

A left popliteal-dorsalis pedis bypass graft was performed using a saphenous vein. Continuous epidural anesthesia time was three hours and operative time was 2 1/2 hours. During much of the procedure, the patient's left lower extremity was positioned with the hip externally rotated and the knee flexed with the lateral aspect of the left heel resting on the operating room table (pressure point).

Postoperatively, the foot became warm with excellent pulsations in the bypass graft and the dorsalis pedis artery. The patient began some walking on the second postoperative day. However, a darkened area developed at the above pres-

sure point and developed into a 4 x 4 cm. ulcer.

The patient was discharged on the 10th postoperative day after undergoing debridement of the necrotic ulcer. The superficial ulcerations present preoperatively rapidly healed in two weeks, but the heel ulcer required six months of outpatient management before healing. Five years after surgery, the graft is patent and the patient has a healthy foot.

Case #2. A 71-year-old, black diabetic male on oral hypoglycemics had severe rest pain for several months in the right foot. Examination revealed a good femoral pulse with absent pulses below. Arteriography revealed a right superficial femoral artery block with an isolated popliteal artery.

A right femoropopliteal bypass was performed under continuous epidural anesthesia with end-to-end anastomoses between graft and artery. Operative time was six hours. The patient's leg was maintained for a prolonged period in the same position, as was the patient's leg in Case #1.

In the immediate postoperative

period, the patient's right heel developed a similar decubitus secondary to this intraoperative pressure.

The patient was discharged on the 14th postoperative day with a right popliteal pulse without more distal pulses. Although the preoperative rest pain was relieved, the heel ulcer never healed. Six months later, the patient underwent a right, below-knee amputation because of the non-healing ulcer and associated pain.

Case #3. An 87-year-old, white, non-diabetic female was admitted with a history of several months of rest pain and gangrene of the right fifth toe with amputation of that toe three weeks prior to this admission. The toe amputation site did not heal. An arteriogram showed complete occlusion of the distal right superficial femoral artery with reconstitution of an isolated 4 cm. segment of popliteal artery.

Under continuous spinal anesthesia, a right femoropopliteal bypass graft using saphenous vein was performed without difficulty.

On the third postoperative day, the patient became comatose with a serum sodium of 109 mg/dl. She remained obtunded and confused for 36 hours, gradually improving with appropriate electrolyte replacement. However, while comatose her right heel was neglected and a 3 x 3 cm. pressure ulcer developed there. This ulcer required debridement and conservative wound care, delaying discharge until the 21st postoperative day.

Within two months of the operation, both the toe amputation site and heel ulcer were completely healed. The bypass graft remains patent and the wounds remain healed.

Case #4. A 74-year-old, white, diabetic female presented with persistent ulcers of the left great and little toes. Prior to admission, the patient had undergone a left fem-

oropopliteal bypass graft. On admission, there was a 2 x 2 cm. ulcer on the medial aspect of the great toe and a 1 x 1 cm. ulcer on the lateral aspect of the 5th toe. Pulses were absent below the left femoral artery.

Preoperative arteriography revealed occlusions of the bypass graft and left superficial femoral artery with reconstitution of an isolated segment of popliteal artery. Under general endotracheal anesthesia, a left femoropopliteal bypass graft was done using a composite vein-Teflon graft. Anesthesia time was five hours and 10 minutes and operating time four hours and 50 minutes.

On the first postoperative day, the patient complained of pain in her left heel from a "sheet burn." Intraoperatively and for the first 24 hours postoperatively, no particular attention had been paid to this heel. The heel continued to deteriorate, with a 3 x 3 cm. ulcer developing although the left lower extremity was warm with a patent graft without distal pulses.

Two weeks postoperatively, transmetatarsal amputation of the 1st and 5th toes was performed. The patient was discharged 21 days after the bypass was performed. On conservative outpatient management, the amputation sites and the heel ulcer initially appeared to be healing nicely. However, three months after surgery, the graft occluded, and the patient underwent a below-knee amputation.

DISCUSSION

The above four detailed cases, plus five additional cases in which the patients developed postoperative heel ulcers, indicate the need for wider recognition of this potential problem and its prevention. One extremity (Case #2) was clearly lost and a second leg (Case #4) perhaps lost because of heel ulcer

development despite a technically successful arterial reconstruction. Moreover, the morbidity and medical care costs of the other patients were increased.

The common denominator in all the cases was some time period, as brief as two hours intraoperatively, in which immobility occurred with continuous pressure on a localized area of the heel leading to tissue necrosis at that point. This period occurred either intraoperatively prior to completion of the arterial reconstruction or postoperatively in patients with occlusion of major arteries distal to the arterial reconstruction.

Prevention of these ulcers requires only simple measures. Intraoperatively, a soft, deep, rubber, inflatable ring can be used. This can be wrapped sterilely and included in the operative field. Alternatively a sterile stockinette can be utilized rolled as a doughnut under the heel. In the immediate postoperative period, heel protectors or foam rings around the lower leg should be used for all immobile patients, i.e., elderly patients with postoperative pain and tenderness in the operative extremity. It would appear advisable to take this precaution in many patients.

The extremities that are most at risk are those that are severely ischemic, and it is precisely in this patient group, in which the results of arterial reconstruction are the most tenuous, that the heel ulcer may be most detrimental.

SUMMARY

Heel ulcers developed in nine patients during or after successful arterial reconstructive surgery, resulting in limb loss in two patients and increased morbidity for the other seven patients. Increased awareness of this potential problem should allow its prevention by simple protective measures.

Tolerance of the Vermiform Appendix to Pressure

**Contrary to the opinion of some, it's safe to give
enemas and cathartics in the presence of appendicitis . . .**

RICHARD J. NOVEROSKE, M.D.
Evansville

The author is a radiologist who maintains a private practice at 3901 Lincoln Ave., Evansville, Ind. 47715.

Acknowledgements:

1. To Con Amore V. Burt, M.D., for allowing me to reproduce data from his pioneering work on the pressure tolerance of segments of the gastro-intestinal tract;

2. To the ARCHIVES OF SURGERY, June 1931, Vol. 22, pp 875-902 (Copyright 1931 by the American Medical Association);

3. To the AMERICAN JOURNAL OF ROENTGENOLOGY, RADIUM THERAPY AND NUCLEAR MEDICINE for the table and drawing of the LaPlace Theorem that previously appeared in their April 1964 issue (Copyright 1964).

I TESTED 45 vermiform appendices to determine their tolerances for high intraluminal pressure.

The specimens were tested by injecting 60cc syringe-fulls of air into a closed system, with the tested appendix on an adaptor tip at one end, and a mercury-filled manometer of 900mm Hg capacity at the other end.

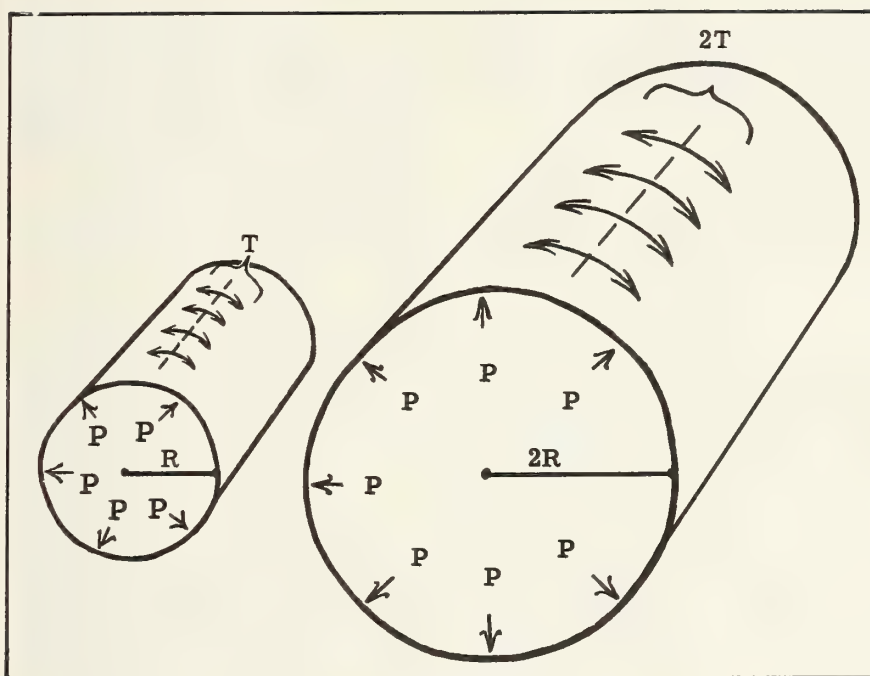


FIGURE 1

The LaPlace Theorem as applied to cylinders: Decreasing the radius decreases the tension that tends to tear apart the wall, even though the pressure remains the same.

Most of the specimens were not inflamed; they had been removed during pelvic surgery. Some specimens were inflamed, and two had perforated. One was too necrotic to measure, and it is not counted among the tested 45 specimens.

The appendices varied considerably in measurement; their lengths varied from 36mm to 120 mm; their diameters varied from 4mm to 15mm, and their wall thickness varied from 0.25mm to 3mm.

Some specimens were tested immediately after removal; some were tested two days later. Some had been fixed in formalin for varying amounts of time, from two minutes to 23 hours. Some had been refrigerated for two to three days. Most of the specimens were moist, but four were dry. These variables made no difference in the results.

The Law of LaPlace as applied to

cylinders (*Figure 1*) indicates that there is an enormous tolerance of the vermiform appendix to intraluminal pressure. And this suggestion is confirmed by the measurements.

There were no gross perforations—no destruction of the integrity of the appendiceal walls—by enormous pressures—usually in excess of 900mm Hg, the capacity of the manometer. Only technique and equipment limited the test pressures. The only perforations were in the two specimens that had been perforated prior to appendectomy. The appendicitis had necrosed a hole through the wall of each of these two specimens, prior to removal and testing. These previously perforated specimens could not take increased intraluminal pressure; as quickly as air was injected into these perforated appendices, it passed out.

There was no difference in the tolerance of the appendices to pressure whether they were inflamed or not. If they were perforated, they had no tolerance, but if intact and inflamed, they withstood the pressure as well as if they were not inflamed. Dry or wet, formalin fixed or not, the appendices repeatedly withstood high intraluminal pressures without bursting.

An interesting, unexpected finding was the bubbling of air through the wall of the intact appendix in eight specimens. This bubbling usually occurred on the mesenteric side, but occurred all around the specimen in one case. This bubbling began at pressures ranging from 200mm Hg to 800mm Hg.

This phenomenon, the bubbling of air through the wall of intact appendices, suggests that this is the mechanism through which pneumatosis cystoides intestinalis occurs—gas is forced from the lumen of the intact intestine through the walls. Cramps, mass peristalses, the Type IV contractions of Code—whatever you wish to call them, can cause increased pressures in the lumen of the colon.² Not so high a pressure would be needed to cause gas to bubble through the wall of the colon with its relatively large diameter, compared with the wall of the appendix. (Law of LaPlace).

An intraluminal pressure of 200 mm Hg in an appendix with a radius of 2.5mm creates a tension in the cylindrical wall that is equivalent to 20mm Hg intraluminal pressure in a cecum with a 25mm radius, or 40mm Hg intraluminal pressure in a sigmoid with a 12.5mm radius. And we know that these levels of intraluminal pressure in the colon are present in humans. Code recorded intracolonic pressures of 70 to 75mm Hg in a patient with a colostomy.²

Because of the enormous tolerance of the non-perforated appen-

dix to high intraluminal pressures, there should be no worry about perforating the inflamed appendix with a barium enema or laxative. The colon will perforate long before the pressure gets high enough to perforate an inflamed, intact appendix. Burt showed perforation of the

cecum in freshly removed specimens from human cadavers, at pressures of 50 and 60mm Hg.¹ (Figure 2)

With these facts in mind, I examined two patients with suspected appendicitis; I used the barium ene-

ma to duplicate the pain that the patients had been complaining of. Surgical and pathological findings confirmed the diagnosis of appendicitis in each case.

There were no perforations in these patients.

FIGURE 2

The bursting pressures in these data follow the Law of LaPlace with segments of larger radii bursting at lower pressures. The serosa splits at a lower pressure; then with higher pressure, the mucosa pops.

BURSTING PRESSURES* OF SECTIONS FROM THE RECTUM** SIGMOID, TRANSVERSE COLON, CECUM, AND ILEUM (AFTER C.V. BURT)											
SEX	AGE	RECTUM		SIGMOID		TRANSVERSE COLON		CECUM		ILEUM	
		Serosa	Mucosa	Serosa	Mucosa	Serosa	Mucosa	Serosa	Mucosa	Serosa	Mucosa
M	5 1/2 mos.	536	646	556	615	318	357	169	307	456	496
F	8 mos.	...	...	278	576	258	332	159	377	...	...
M	11 yrs.	...	...	526	605	...	...	...	...	258	397
F	21 yrs.	238	258	278	318	139	179	60	139	437	437
F	30 yrs.	...	...	119	292	79	214	40	50	179	198
M	30 yrs.	...	...	179	188	60	119	...	...	139	139
M	37 yrs.	...	...	139	159	...	...	57	99	179	179
M	42 yrs.	...	...	198	238	99	149	109	149	139	139
M	42 yrs.	...	...	139	139	99	156	...	...	159	318
				119	168						
M	43 yrs.	...	...	139	139	89	114	79	119	278	278
M	45 yrs.	99	109	139	149	79	89	...	...	278	278
F	50 yrs.	...	...	139	159	...	...	...	...	228	258
F	60 yrs.	...	...	119	179	40	79	79	99	278	278
F	60 yrs.	...	...	134	179	99	119	40	79	...	...
						79	109				
M	62 yrs.	...	...	248	258	79	139	60	99	238	238
M	64 yrs.	...	...	60	154	89	95	60	60	159	159
M	78 yrs.	198	198	119	179	119	149	50	60	248	248

*Segments of gut were perforated with compressed air; rate of pressure increase was about 20 mm Hg per second. These pressures, tabulated in psi in Dr. Burt's paper, have been divided by 0.01915 to convert them to mm Hg.
**Segments of rectum were dissected out of the pelvis, prior to testing.

PATIENT #1

This 20-year-old man was admitted from the emergency room with a complaint of pain in the right lower quadrant of the abdomen. The pain had been present for 14 hours before admission.

Physical examination showed marked tenderness over McBurney's Point. Rectal examination was unremarkable.

The past history revealed frequent bouts of pain in the right lower quadrant.

The white blood cell count at the time of admission was 12,000, with 73 segs and 5 stabs.

The chest x-ray was normal. A barium enema examination was done two days later; it showed an anatomically normal colon and terminal ileum with reflux of the vermiform appendix. The filling of the cecum and rest of the proximal ascending colon duplicated the right lower quadrant pain that the patient had been complaining of.

At surgery, done four days after admission, an acutely inflamed appendix—inflamed at the tip—was found. No Meckel's Diverticulum was found.

The pathologist reported a seven-centimeter-long appendix with hyperemia of the distal one-third. The wall was thickened, and the lumen contained yellow, mucoid material. No fecalith was present. Diagnosis: acute appendicitis.

The post-operative course was satisfactory. The patient was discharged with no complications.

PATIENT #2

This 42-year-old man was admitted for laparotomy. Several weeks before, the patient had right lower quadrant and lower abdominal pain; the white blood cell count at that time was about 7,000. The patient was treated symptomatically, and the pain disappeared. Two to three weeks later, the right lower

quadrant pain recurred; the white blood cell count was 12,500, and there was moderate tenderness in the right lower quadrant of the abdomen. The patient was again treated symptomatically, and he did better.

A barium enema was done five days prior to this admission for surgery. At fluoroscopy I was able to duplicate the right lower quadrant pain that the patient had been complaining of, by the filling of the colon with the barium suspension. I was not able to fill out the cecum at fluoroscopy despite two to three minutes of extra time to attempt to fill it out. The examination was painful to the patient, and I had to stop because of the pain, even though the cecum had not filled out. The x-ray films showed a normal colon except for a cecum that would not distend in a normal manner.

At surgery a large edematous mass was seen arising from the cecum in the area of what would normally be the appendix. It was removed. The white blood cell count at the time of this elective surgery was 8,200 with 76 segs.

The pathologist's diagnosis was "subacute appendicitis and periappendicitis."

The patient did well postoperatively; he stopped by to see me six weeks after surgery, and he told me that he had made a good recovery.

I thought that I might have a specific criterion for the diagnosis of appendicitis by the barium enema, i.e., the duplication of patient's pain by the barium enema examination. But I have learned that this duplication occurs more often with irritable colon, and it can be helpful in diagnosing this entity. I also had a patient with an ovarian cyst, subsequently shown at surgery, in whom the barium enema duplicated her pain; this experience shows that a third diagnostic possibility can be

considered when the barium enema duplicates the patient's pain.

CONCLUSIONS

● The vermiform appendix has an enormous tolerance for increased intraluminal pressure, in excess of 900mm Hg.

● Bubbling of air through the intact wall of the appendix occurred in eight specimens. This finding suggests the cause of pneumatosis cystoides intestinalis.

● The barium enema and laxatives are safe in the presence of appendicitis. They will not cause perforation. If perforation of the appendix is found, it is due to prior necrosis and perforation of the wall of the appendix.

● The duplication of the patient's abdominal pain by the barium enema examination is not definitely diagnostic, but it can be suggestive or supportive of acute appendicitis; other possibilities such as irritable colon or ovarian cyst can be present.

REFERENCES

1. Burt, Con Amore V: Pneumatic Rupture of the Intestinal Canal with Experimental Data Showing the Mechanism of Perforation and the Pressure Required. *Archives of Surgery*, 22: 875-902, June 1931.
2. Code, Charles F, et al: Normal and Some Abnormal Colonic Motor Patterns in Man. *Annals of the New York Academy of Sciences*, 58:317-334, Article 4, July 15, 1954.
3. Noveroske, Richard J: Intracolonic Pressures During Barium Enema Examinations. *American Journal of Roentgenology, Radium Therapy and Nuclear Medicine*, 91(4):852-863, April 1964.

BOOK REVIEWS



Gynecologic and Obstetric Urology

Herbert J. Buchsbaum, M.D., and Joseph D. Schmidt, M.D., and 29 contributors. W. B. Saunders Company, W. Washington Square, Philadelphia 19105, Copyright 1978. 461 pages with 266 illustrations, \$35. (Dr. Buchsbaum is professor of obstetrics and gynecology and director, Division of Gynecologic Oncology, University of Iowa College of Medicine; Dr. Schmidt is professor of surgery/urology and head, Division of Urology, University of California.)

In their introduction the authors/editors state: "With this volume we hope to provide the physician who treats female pelvic disease with a current textbook of gynecologic and obstetric urology. In addition to the traditional subjects, there are chapters on asymptomatic bacteriuria, pregnancy in renal transplant recipients, suprapubic bladder drainage, and the urinary tract in genital anomalies and infertility. . . . This collaborative effort had its origins at the University of Iowa, where the urology and gynecology operating rooms were adjacent and shared a common scrub area." They also comment aptly by quoting T. Millin (1949): "Our two specialties (gynecology and urology) cannot remain watertight compartments when it is the patient we are endeavoring to make watertight."

There are 28 different papers by the 31 authors, only 11 of whom are from Iowa City. The remainder are from various parts of the United States and Canada, including one from Franklin, Indiana (Margaret B. Aydelotte, M.A., Ph.D., Associate Professor of Biology, Franklin College) who wrote the chapter on Developmental Anatomy (Chapter 1).

The work is divided into five sections of from four to nine chapters each: Section I—Anatomy, Physiology, and Examination of the Female Genitourinary Tract; Section II—Operative Ob-

stetrics and Gynecology; Section III—Urinary Incontinence; Section IV—Inflammatory and Neoplastic Disease; Section V—The Genitourinary Tract in Pregnancy. Section III has the most chapters (9), but in my opinion this should be the case, since so many techniques of treatment have been proposed, advocated, and debated and this book attempts a complete and logical approach toward clarifying the problem. To quote again: "The standard vaginal and abdominal procedures are presented, as well as a newly modified combined procedure. In addition, two operations are presented for the correction of persistent urinary stress incontinence following failure of surgical repair." Of course, the various fistulas are also considered in this section, as well as neurogenic bladder, anatomic defects, etc.

In Section II attention is given to the urinary tract in radical hysterectomy, urinary diversion in pelvic exenteration, and postoperative bladder drainage, along with a treatise on the urinary tract "in clinical and surgical gynecology and obstetrics".

One of the most interesting and valuable chapters is the one on gynecologic and obstetric problems in renal allograft recipients, and this discussion could be read with great profit by any generalist, especially if in family practice, as well as by students and internes, as it deals in a succinct, clear manner with the whole patient as she is affected by immunosuppression.

Each chapter has its own list of references and the illustrations and tables are numerous. Over the years we have learned to expect fine medical books from W. B. Saunders Co., and this one is right in line with that expectation.

A. W. CAVINS, M.D.
Gynecologist
Terre Haute

Why Some Infants Fail to Thrive . . .

CONTINUED FROM PAGES 1129-1132

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202.**

ANSWER THE FOLLOWING:

1. If a baby does not gain on a formula that is quantitatively and qualitatively correct, the first thing to do is:
 - a. Change the formula
 - b. Increase the amount taken
 - c. Consider the presence of some disorder in the infant or mother-infant interaction
 - d. Add solid foods
2. An infant with paradoxical alertness, euphoria and hyperactivity in the presence of emaciation may have:
 - a. Gluten-induced enteropathy
 - b. Renal tubular acidosis
 - c. Disaccharide intolerance
 - d. Diencephalic syndrome
3. Failure to gain weight in spite of large food intake suggests:
 - a. Disaccharide intolerance
 - b. Cystic fibrosis
 - c. Celiac syndrome
 - d. Malignancy
4. The most common cause of failure to thrive in infants is:
 - a. Endocrine
 - b. Chronic infection
 - c. Malabsorption
 - d. Psychosocial
5. A good screening test for failure to thrive is:
 - a. Dietary history
 - b. Routine weighing of infant
 - c. Hemoglobin
 - d. Caliper measure of subcutaneous fat over the triceps

The following are answers to the CME quiz that appeared in the September 1978 issue of The Journal. The article upon which the questions were based was "A Simplified Approach to Dysfunctional Uterine Bleeding," by Leo M. Bonaventura, M.D., and Robert E. Cleary, M.D.

1. b
2. c
3. a
4. c
5. b
6. d
7. d

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer sheet for Quiz: (Infants . . .)

1. a, b, c, d
2. a, b, c, d
3. a, b, c, d
4. a, b, c, d
5. a, b, c, d

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for credit for this month's quiz, send your completed, signed application before February 15, 1979, to the address appearing at the top of this page.

BOOK REVIEWS

Heart Attack! A Question and Answer Book

Oscar Roth, M.D., F.A.C.C., Copyright 1978. Lippincott, 521 Fifth Ave., New York, NY 10017. 262 pages, \$8.95.

This outstanding book is well written, concise and informative. It is written in a language that can be understood by lay people. It carries merit even among physicians since it is quite informative in its assessment of angina pectoris, heart attack, the treatment of heart attack, the follow-up of heart attack, the question of risk factors and the medical and surgical management of coronary artery disease. It also is up to date in its diagnostic methods of assessing the topic of "Coronary Artery Disease."

The book is especially useful for patients who have sustained heart attacks or who have

angina pectoris. It describes in detail and in an easily understandable manner the "do's and don'ts" associated with heart attacks. It attempts to alleviate the fears of people who have sustained heart attacks.

This book should be available in the office of every clinical physician and clinical cardiologist. Dr. Roth is without question an excellent writer, and his book demonstrates his vast experience in patients who have had heart attacks; his knowledge of the literature, both old and recent, is evident.

It is a delight to read a book so well written and informative.

WILLIAM K. NASSER, M.D.
Cardiovascular Diseases
Indianapolis

Business Opportunities: Tax Shelters For Professionals

If you're in a higher tax bracket, you'd probably like to reduce your present tax liabilities without reducing income. There is a way.

Tax free municipal bonds offer distinct advantages over other investments. In addition to high yields and tax free income, you also get low risk, diversity, capital appreciation, and marketability.

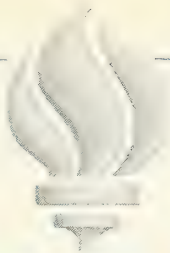
Many of the investments we offer are Indiana issues which are exempt from Indiana Intangibles Tax plus Indiana Gross Income Tax. At American Fletcher there is no annual management fee or commission charged on municipals. For a small fee (tax deductible) our Safekeeping staff will clip and collect your coupons for deposit to your checking or savings account.

American Fletcher can help. Our Portfolio and Money Market Group can acquaint you with the investment opportunities available in municipal bonds.

Call us today at (317) 639-8070 or address inquiries to: Portfolio and Money Market Group, American Fletcher National Bank, 101 Monument Circle, Indianapolis, Indiana 46277.

**"Give your income a shot
in the arm with tax free
Municipal Bonds from
American Fletcher."**

We want to be your bank.
AMERICAN FLETCHER
NATIONAL BANK
AFNB



ROCKWOOD

INSURANCE COMPANY OF INDIANA

Professional Liability Insurance Specialists

Physicians, Surgeons, Dentists

Hospital Professional Liability

Represented by:

Health Care Provider Insurance Agency, Incorporated

INDIANAPOLIS . . . Hadley-Mahoney Co., 3640 N. Washington Blvd. 46205
(317) 924-5331

MICHIGAN CITY . . . Lindenmeyer Insurance Associates, Inc.
801 East Eleventh Street 46360
P.O. Drawer C
(219) 879-7301

SEYMOUR Wienco, Inc., Room 20, Vehslage Building
P.O. Box 518 47274
(812) 522-2931

SOUTH BEND Hepler-Smith Insurance, Inc.
511 West Colfax Avenue
P.O. Box 1875 46634
(219) 232-4889 (Toll Free 1-800-552-2910)

NEWS NOTES

THE WINNERS—129th Convention

SCIENTIFIC EXHIBITS: The top three winners, selected on the basis of excellence, were:

First award—Malcolm B. Herring, M.D., Indianapolis, "Endothelium-lined Arterial Prostheses."

Second award—Arnold M. Belker, M.D., Louisville, Ky., "Microsurgical Vasovasostomy Compared to Standard Techniques: A Closer Look."

Third award—Donald G. Blair, M.D., U.S. Navy, Washington, D.C., "Ultrasonography in Obstetrics and Gynecology."

GOLF TOURNEY: Winners of the Men's and Women's Golf Tournament, held Oct. 23, at Jeffersonville Elks Club, were:

Low Gross—Reuben Balinao, M.D., Michigan City;

Low Net—Richard Jordan, M.D., Clarksville;

Low Net (Women)—Betty Dalton, Shelbyville.

TENNIS TOURNEY: Winners of the Men's and Women's Singles and Doubles, conducted Oct. 23 at the Kentuckiana Sports Center, Clarksville, were:

Men's Singles—Frank Vinicor, M.D., Indianapolis;

Women's Singles—Kay Clark, Plainfield;

Men's Doubles—Frank Vinicor, M.D., and Richard Powell, M.D., Indianapolis.

Cost Containment Plan

Cost containment for Indianapolis hospitals has been furthered by formation of Hospital Shared Services/Alliance of Indianapolis Hospitals, Inc. Indiana University trustees have approved participation of the Indiana University Hospitals in the new venture, making a total of nine Indianapolis hospitals as participants. Initially, the program will include shared purchasing services, medical transcription services and microfilm service. Other share services may be added later.



'Practical Internal Medicine'

"Practical Internal Medicine for the Practitioner" will be the subject of an Ochsner Medical Institutions continuing medical education seminar to be held in New Orleans Friday and Saturday, March 30 and 31, 1979. It is rated for 12 credit hours. For details, write Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, La. 70121.



McClain Car Leasing, Inc.

1745 Brown St., Anderson, Ind.

Phone 317/642-0261

Specializing in Professional Car Leasing

ALL MAKES AND MODELS AVAILABLE

We are proud to offer a Leasing Plan approved by ISMA

NEWS NOTES

Hospital CME Accreditations

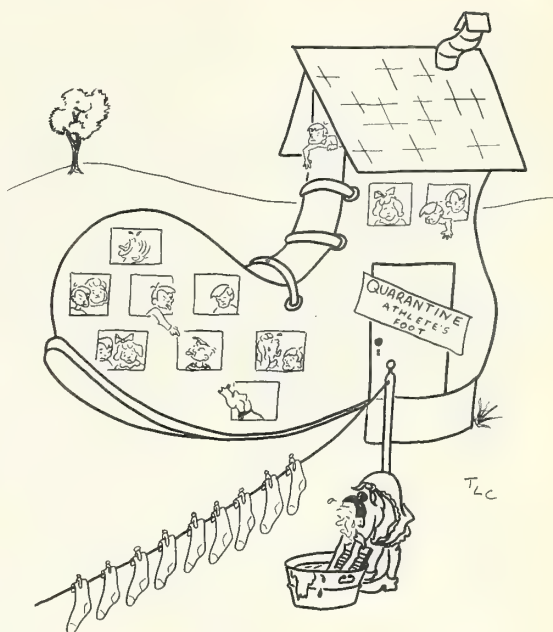
Thirty-three Indiana hospitals and 21 non-hospital institutions have been granted Continuing Medical Education accreditation. Such accreditation certifies that the hospitals provide scientific programs that meet the essentials for CME programs as established by the Liaison Committee on Continuing Medical Education and by the AMA. Programs certified by the hospital director of medical education to be Category 1 may be included in a physician's application for the Physician Recognition Award.

Based on recommendations by the ISMA Commission on Medical Education, the following hospitals have been CME accredited:

The Lutheran Hospital of Fort Wayne, Indiana
 Parkview Memorial Hospital, Inc.—Fort Wayne
 St. Joseph's Hospital of Fort Wayne, Inc.
 Bartholomew County Hospital—Columbus
 Dearborn County Hospital—Lawrenceburg
 Ball Memorial Hospital—Muncie
 Howard Community Hospital—Kokomo
 St. Joseph Memorial Hospital of Kokomo, Indiana, Inc.
 Huntington Memorial Hospital—Huntington
 Good Samaritan Hospital—Vincennes
 The Methodist Hospital of Gary, Inc.
 St. Catherine Hospital of East Chicago, Indiana, Inc.
 St. Margaret Hospital—Hammond
 St. Mary Medical Center, Inc.—Gary
 LaPorte Hospital—LaPorte
 Mercy Hospital, Inc.—Elwood
 St. John's Hickey Memorial Hospital—Anderson
 Community Hospital of Indianapolis, Inc.
 Indiana University Hospitals—Indianapolis
 Methodist Hospital of Indiana, Inc.—Indianapolis
 St. Vincent Hospital and Health Care Center, Inc.—Indianapolis
 Bloomington Hospital—Bloomington
 Memorial Hospital of South Bend
 St. Joseph's Hospital—South Bend
 Lafayette Home Hospital, Inc.—Lafayette
 St. Elizabeth Hospital Medical Center—Lafayette
 Deaconess Hospital—Evansville
 St. Mary's Hospital Medical Center of Evansville, Inc.
 Welborn Memorial Baptist Hospital, Inc.—Evansville
 Terre Haute Regional Hospital—Terre Haute
 Union Hospital, Inc.—Terre Haute
 Reid Memorial Hospital, Inc.—Richmond
 Caylor-Nickel Hospital, Inc.—Bluffton

Those non-hospital institutions that have been CME accredited are:

Aesculapian Society of the Wabash Valley
 American College of Surgeons Indiana Chapter
 Fort Wayne Academy of Medicine and Surgery
 Fort Wayne Anesthesia Society
 Fort Wayne Medical Education Program
 Hawley Army Health Clinic, Ft. Harrison, Indiana
 Indiana Academy of Ophthalmology & Otolaryngology, Inc.
 Indiana Obstetrical & Gynecological Society
 Indiana Association of Pathologists
 Indiana Orthopaedic Society
 Indiana Philippine Medical Society
 Indiana Psychiatric Society
 Indiana Society of Anesthesiologists
 Indiana Society of Internal Medicine
 Indiana State Board of Health
 Lafayette Medical Education Foundation
 Medical Education Foundation of Southwestern Indiana
 Second District Medical Society
 St. Joseph County Medical Society
 Terre Haute Academy of Medicine
 Wright Institute of Otolaryngology, Inc.



this publication is available in microform



Please send me additional information.

University Microfilms International

300 North Zeeb Road
 Dept. P.R.
 Ann Arbor, MI 48106
 U.S.A.

18 Bedford Row
 Dept. P.R.
 London, WC1R 4EJ
 England

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

Dr. Popplewell Named President-Elect



Dr. Arvine G. Popplewell of Indianapolis was elected president-elect of the Indiana State Medical Association Oct. 25, during the 129th annual convention in Clarks-ville. He will assume the presidency of ISMA in October 1979.

Dr. Popplewell, a 1946 graduate of Indiana University School of Medicine, is a specialist in pulmonary diseases. He is a Fellow of the American College of Chest Physicians and a member of the American Thoracic Society.

Since 1973 Dr. Popplewell has been a professor, Department of Medicine, I.U. School of Medicine.

He is a member of the board of directors of both the American Lung Association of Central Indiana and the American Lung Association of Indiana. He also is a board member, Home Care Agency of Greater Indianapolis, Inc., the Downtown Kiwanis Club, Indianapolis. Since 1975, he had served as Treasurer of ISMA.

Fort Wayne Picked for Health Study

A 15-month study of chronic obstructive pulmonary disease outpatient rehabilitation programs will be conducted in Fort Wayne, one of three sites selected in the country by the American Lung Association. Locally, the study will be handled by the American Lung Association of Northeast Indiana and the Lutheran Hospital Respiratory Therapy Department. The other two sites are Buffalo, N.Y. and Hartford, Conn. Directing the study in Fort Wayne is Dr. Thomas Hayhurst, medical director of the Respiratory Department at Lutheran and medical consultant of the American Lung Association of Northeast Indiana.

Dr. McIntosh Joins HCA Panel

Dr. Wilbert McIntosh, a Riley general practitioner, has been appointed to a three-year term on the board of governors of Hospital Corporation of America (HCA), the nation's leading hospital management company, headquartered in Nashville, Tenn. HCA operates 110 hospitals with more than 17,000 beds in 25 states and four foreign countries. Terre Haute Regional Hospital, where Dr. McIntosh is chairman of the board of directors, is one of two facilities HCA operates in Indiana.

CDC to Study Legionnaires Disease

Bacteria that causes Legionnaires Disease is "essentially universal," so there is no way to tell where the disease might occur, according to Dr. David Fraser, chief of the special pathogens branch, national Center for Disease Control (CDC), Atlanta. "We've had cases in 40 states and four continents," he said. Dr. Fraser pointed out that, since the disease was first isolated in Philadelphia two years ago, an antibiotic has proved successful in treatment and a vaccine may be developed to prevent the disease.

The CDC will direct a five-year investigation of Legionnaires Disease to determine how it flourishes and to find ways to prevent it, Dr. Fraser said.

Army Film on Shock Available

A medical training film, "Emergency Medical Care: Shock," produced by the U.S. Army, is available on loan from Materials Utilization Branch, National Medical Audiovisual Center, Annex, Station K, Atlanta, Ga. 30324. It is 16mm in color and with sound—17 minutes running time. It discusses diagnosis and treatment of hemorrhagic and neurogenic shock.

HANGER'S NETWORK OF PROSTHETIC CARE= ADDED SECURITY

Understandably, the assurance that proper prosthetic care will be available when and where it is needed is of great concern to wearers of prostheses.

HANGER, makers of quality prostheses, provides a country-wide network of convenient offices where complete adjustment, repair and consultation services are available. Each HANGER office is staffed with one or more certified Prosthetists and contains a full line of HANGER Standard Parts and supplies to insure the same high quality prosthetic service as was obtained at the original HANGER location.

In keeping with the tradition of quality Prosthetic service, every HANGER office is proud to honor the guarantee furnished by every other HANGER office.

In Today's mobile society, for convenience and for quality, HANGER is the leading name in Prostheses.

Hanger
PROSTHETICS

1332 N. Illinois St., Indianapolis, Indiana 46202
312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

NEWS NOTES

Health Hazard Profile

The health hazard profile evaluation, which was pioneered in Indianapolis, was given a big boost by Dr. Robert Acher of Greensburg when he addressed the 4th annual meeting of the Society of Prospective Medicine at St. Petersburg, Florida recently. The method, which was organized by Dr. Lewis C. Robbins and Dr. Jack H. Hall of Methodist Hospital in Indianapolis, specifies a patient's risks and chances of survival, determines which risks are reducible and outlines what the patient should do to reduce the risks. Dr. Acher said that the method is valuable for physicians "who believe that, just as there is a time for healing, for many fortunate people there is yet the time for prevention."

Hoosier Assumes VA Post

Dr. Donald L. Custis, a native of Goshen, Ind., and graduate of Wabash College, has been named as deputy chief medical director of the Veterans Administration. Dr. Custis served with the U.S. Navy from 1944 to 1946, after which he was in the private practice of surgery in Seattle for 10 years. After another term of service with the Navy, he was selected as Surgeon General of the Navy in 1973.

Second Opinions Will Not Lower Costs

Shortly after DHEW formally announced the start of its surgical second-opinion program, Dr. James H. Sammons, AMA executive vice-president, told the press that the program "promises to increase utilization of physician services as Medicare and Medicaid patients across the country are urged to seek a second opinion before all nonemergency surgery." Dr. Sammons refuted DHEW's claims that its national second-opinion program would be cost reducing. Short-term results of several experimental second-opinion programs "have not provided clear evidence," he said, "that a national program of this type will either improve the quality of care or reduce health cost."

'Home Health Care'

"Home Health Care: When a Patient Leaves the Hospital" is a new Public Affairs Pamphlet, written by well known health writer, Theodore Irwin. He explains when home health care is desirable, how it can cut medical costs, why it is an alternative to nursing homes for some persons, and describes the kinds of services available. The 28-page pamphlet is available for 50 cents. Write Public Affairs Committee, 381 Park Avenue South, New York City, 10016.

Fellowships

The following ISMA members have been admitted to Fellowship in the organizations indicated:

American College of Cardiology:

Dr. William R. Storer, Indianapolis;
Dr. Robert E. Swint, Sr., Fort Wayne.

American College of Surgeons:

Dr. Edward L. Brundick, Jr., Evansville;
Dr. Charles K. Fischer, Evansville;
Dr. Alan T. Marty, Evansville;
Dr. H. S. Daugherty, Fort Wayne;
Dr. Kenneth F. Isenogle, Fort Wayne;
Dr. Norman A. Kempler, Fort Wayne;
Dr. Daniel L. Paflas, Fort Wayne;
Dr. Philip O. Shriner, Fort Wayne.

American Academy of Family Physicians:

Dr. A. M. Montecillo, Terre Haute;
Dr. Robert M. Kelsey, Jr., LaPorte;
Dr. Don P. Zent, Kokomo;
Dr. Joventino Naval, South Bend;
Dr. R. Wyatt Weaver, Jr., Angola;
Dr. Donald G. Sturgis, Jeffersonville.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Indiana State Medical Association

Immediate delivery on many 1979 models

We lease all foreign and domestic makes and
models including Mercedes, Jaguar,
Porsche, BMW, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition we want to lease
you any professional equipment that can be de-
preciated.

Immke Circle Leasing Inc.
32 South Fifth Street
Columbus, Ohio 43215

Call Collect
Telephone 614-228-1701 or
317-472-3594

NEWS NOTES

40 Scholarships Awarded

\$300 scholarships have been awarded to 40 paramedical and parodontal students by Duke's Day, Inc., a non-profit organization of physicians, dentists, pharmaceutical salesmen and druggists. The Fort Wayne group conducts an annual outing to raise funds to aid medical education students (see *THE JOURNAL*, p. 858, Vol. 71, No. 9, Sept., 1978). Proceeds from the 9th annual event, held this summer, were so great that the amount of the scholarships was raised from \$250 to \$300, according to Dr. Philip O. Shriner, president. Since it was organized in 1972, Duke's Day has granted scholarships totaling nearly \$63,000 to medical education students.

'The Untouchable Heart'

"The Untouchable Heart," a popular pamphlet published by the National Society for Medical Research, has been revised and is ready for distribution. It traces the history of man's attempt to understand and minister to the heart. The 16-page text is supplemented with prints, diagrams and photographs of both historical and contemporary interest. The first copy requested is free, with additional copies at 50 cents each. Write the NSMR at 1000 Vermont Ave., N.W., Washington, D.C. 20005.

Indianapolis Team Wins Award

Drs. T. F. Schlegel, Jr., Daniel H. Spitzberg, Kenneth G. Julian and Eugene E. Loudon of Indianapolis and Dr. C. Joseph Anderson of Madison, Wis. won the second place award for a scientific exhibit they showed at the annual meeting of the American Academy of Ophthalmology. The exhibit, "Human Leukocyte Antigens (HLA) and Uveitis," demonstrates a means for the ophthalmologist to identify an individual's susceptibility to two common eye diseases.

No Toll-Free Number for CHAMPUS

The new CHAMPUS contractor for Indiana and Kentucky, Blue Cross of Southwestern Virginia, will NOT have a toll-free telephone number as originally announced. Their headquarters, in Roanoke, Va., can be reached at 703-989-3384 or 703-989-3385. The new CHAMPUS contract went into effect Sept. 15.

Directory of Access Guides

Rehabilitation International USA has a 16-page directory that lists 275 access guides. The guides are handbooks which describe an area's hotels, restaurants, theaters, churches and transportation facilities in terms of their physical accessibility to the handicapped. A free copy of the directory may be ordered by writing to Access Guide Directory, 20 W. 46th St., New York City 10018.

Here and There . . .

. . . **Dr. Gary A. Babcoke** of Valparaiso has been named to a four-year term as health officer of Porter County.

. . . **Dr. J. William Wright Jr.** of the Wright Institute of Otology, Indianapolis, has been named president-elect of the American College of Otolaryngology.

. . . **Dr. E. Robert Jacobs** of Columbus has been appointed health officer by the Bartholomew County Board of Health. He will replace Dr. William B. Sigmund, also of Columbus.

. . . **Dr. James H. Gosman** of Indianapolis has been elected president of the board of advisors for Indiana-Purdue University.

. . . **Dr. Edward U. Murphy** of Evansville is a new member of the University of Evansville board of trustees.

. . . **Dr. W. Proctor Harvey**, Professor of Medicine, Georgetown University School of Medicine, Washington, D.C., was guest speaker during the Fourth Annual Arthur B. Richter Lectureship, held Oct. 18 at St. Vincent Hospital, Indianapolis.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of *The Journal*. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.

COMMERCIAL ANNOUNCEMENTS

Commercial announcements are carried in The Journal as a special service to ISMA members. Only advertisements considered by publisher to be of advantage to members will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

20¢ for each word

\$4.00 minimum

Send cash with order. Average count: seven words to the line.

Address: The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

DEADLINE: Fifth day of month PRECEDING month of issue.

FAMILY PRACTICE PHYSICIAN(S) WANTED—To take over excellent practice in southern Indiana from physician wishing to retire. Well located, beautiful clinic-type office building large enough for one or more physicians. Ample parking. Will assist in transition for 1 or 2 years if desired. Contact W. E. Schoolfield, M.D., 260 S. Maple St., Orleans, Ind. 47452. Tel: (812) 865-3350 or (812) 865-3351.

LOCUM TENENS—EMERGENCY MEDICINE—available in our 100 hospitals; monthly scheduling is flexible and according to your preferences; malpractice is paid, excellent hourly income according to your flexibility and hours worked. Call toll free 1-800-325-3982, ext. 220 for details.

FAMILY PRACTITIONER OR INTERNIST full time for 60-bed comprehensive alcoholism treatment center with plans for expansion to 100+ beds and expanded outpatient services. Will work closely with and share coverage with three other full time physicians, and be responsible for initial medical evaluation, detoxification, treatment of medical problems and complications. Opportunity for involvement in teaching of medical students, residents, physicians and other health professionals. **SALARY NEGOTIABLE (\$50,000+)** and excellent fringe benefits, including 4 weeks vacation, paid CME, paid health, disability and liability insurance. **QUALIFICATIONS:** M.D. with additional training and experience in Family Practice or Internal Medicine, sincere interest in treating alcoholics and Indiana Medical License, Board Certification and previous experience in Alcoholism Treatment preferred. **CONTACT:** Gerald P. Johnston, M.D., Medical Director, Fairbanks Hospital, Indianapolis, Ind. 46202. Tel: (317) 638-1574.

IMMEDIATE OPENING for full-time (40-hour week) Indiana licensed physician in training center for mentally retarded. Fringe benefits include health and life insurance, excellent retirement program, accumulative sick and vacation leave. Rotate night and weekend "call" with four other physicians compensated by time off. For further information or application, contact George Smith, Personnel Director, Fort Wayne State Hospital and Training Center, 4900 St. Joe Road, Fort Wayne, Ind. 46815. Tel: (219) 485-7554.

PHYSICIAN'S OFFICE AVAILABLE FOR RENT—Space for two physicians, with off-street parking, with or without equipment and furniture. Immediate availability. Contact Robert C. McAdams, M.D., 2011 Kossuth, Lafayette, Ind. 47905. Tel: (317) 447-4904 or (219) 583-8529.

SPONSOR FOR PRECEPTOR NEEDED. Passed the FLEX and have had more than five years experience in Anesthesia. Willing to work in any specialty. Contact Mahendra J. Patel, M.D., 4928 Glendale Ave. #3, Toledo, Ohio 43614. Tel: (419) 729-5151 (hospital), or (419) 382-0112 (residence).

TWO BOARD CERTIFIED FAMILY PHYSICIANS need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please send curriculum vitae to Link, Chapman & Associates, Inc., 1515 W. Truman Road, Independence, Missouri 64050, or call collect (816) 836-8200 between 9 a.m. and 4:30 p.m.

MICHIGAN CITY, INDIANA—Emergency Department Director; flexible scheduling. Excellent income—\$57,000 to \$65,000. Paid malpractice insurance. Contact T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, Missouri 63141, or call toll free 1-800-325-3982.

OPPORTUNITIES FOR PHYSICIANS—There are several excellent openings among the Indiana State Hospitals at various locations throughout the State for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Candidates must be licensable in Indiana. Please reply with a copy of the c.v. to: FARABEE & ASSOCIATES, INC., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

THE INDIANA STATE DEPARTMENT OF PUBLIC WELFARE has a position available for a physician to work in a pleasant office atmosphere; no patient contact; no malpractice insurance required; an Indiana license or eligibility is required; competitive salary; regular working hours; excellent fringe benefits. Contact: Personnel Director, Indiana State Department of Public Welfare, 702 State Office Building, 100 N. Senate Ave., Indianapolis 46204. Phone: (317) 633-6403.

FOR LEASE: On Vanderbilt Beach near Naples, Fla., two-bedroom, two-bath new condominium on the beach. Docking facilities available. Tel: (317) 644-6147.

PHYSICIANS' DIRECTORY

INTERNAL MEDICINE

NEUROSURGERY

Offices for the doctors listed below are located at 3130 N. Meridian St., Indianapolis 46208; the switchboard number is 317-927-1221.

MERIDIAN MEDICAL GROUP

CARDIOLOGY

Richard M. Nay, M.D.
Warren E. Coggeshall, M.D.
Richard R. Schumacher, M.D.
William C. Elliott, M.D.

HEMATOLOGY—ONCOLOGY

Laurence H. Bates, M.D.
William M. Dugan, M.D.
James E. Schroeder, M.D.
Frank A. Workman, M.D.
Deborah S. Provisor, M.D.
Pediatrics

METABOLISM AND ENDOCRINOLOGY

William M. Holland, M.D.

GASTROENTEROLOGY

Robert D. Pickett, M.D.
B. T. Maxam, M.D.
Lee G. Jordan, M.D.
Martin P. Meisenheimer, M.D.

INTERNAL MEDICINE

Hunter A. Soper, M.D.
Douglas H. White, Jr., M.D.
Michael B. DuBois, M.D.

Nephrology

Michael P. Bubb, M.D.
Robert L. Iverson, Jr., M.D.
Critical Care

Michael Zeckel, M.D.
Infectious Diseases

INFECTIOUS DISEASES

Thomas G. Slama, M.D.

NEUROLOGY

Norman W. Oestrike, M.D.
Charles Rehn, M.D.

By Appointment

Phone 925-4255

C. BASIL FAUSSET, M.D.

Neurological Surgery

1815 North Capitol Avenue

Indianapolis 46202

By appointment only

Phone 317-353-6800

BIO MEDICAL LABORATORY

5506 East 16th St., Suite 24
Indianapolis 46218

Bio-Feedback Training for Migraine and Tension Headache
KARL L. MANDERS, M.D.

JOHN S. MARKS, JR., M.D.

MALCOLM S. SNELL, M.D.

NEPHROLOGY & INTERNAL MEDICINE, INC.

Daniel J. Ahearn, M.D.

Thomas Wm. Alley, M.D., FACP

George W. Applegate, M.D.

Charles B. Carter, M.D.

William H. Dick, M.D., FACP

Theodore F. Hegeman, M.D.

Douglas F. Johnstone, M.D.

LeRoy H. King, Jr., M.D., FACP

2020 W. 86th St., #307, Indianapolis 46260 Ph: 317-844-9911
1633 N. Capitol, #722, Indianapolis 46202 Ph: 317-926-0757

Answering Service 926-3466

CLINICAL NEPHROLOGY, RENAL TRANSPLANTATION, HEMODIALYSIS, PERITONEAL DIALYSIS, HYPERTENSION, FLUID AND ELECTROLYTE IMBALANCE, CRITICAL CARE.

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

HAND SURGERY

By appointment

Phone 317-783-1319

VIDYASAGAR S. TUMULURI, M.D., F.A.C.S., INC.

Diplomate American Board of Surgery
Acute & Reconstructive Hand Surgery
General Surgery

3530 S. Keystone, Suite 305

Indianapolis 46227

PHYSICIANS' DIRECTORY

PSYCHIATRY

JOHN H. GREIST, M.D.

Diplomate, Board of Neurology and Psychiatry

Specializing in Psychiatry

3231 North Meridian Street

Indianapolis 46208

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALCOHOLISM TREATMENT

GERALD P. JOHNSTON, M.D.
BRADLEY N. BOEN, M.D.
PAUL M. FLANAGAN, M.D.
HAROLD G. NICHOLS, M.D.

Comprehensive Alcoholism Treatment

Fairbanks Hospital
1575 Northwestern Avenue
Indianapolis, Ind. 46202

(317) 638-1574

\$120 per year will keep your name before the medical profession in this space for one year. For information contact THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

ALLERGY

INDIANA ASTHMA & ALLERGY ASSOCIATES

Specializing in Chronic Severe Asthma

and

Adult and Pediatric Allergic Disorders

D. Duane Houser, M.D., Inc.

(317) 923-7650

and

Douglas J. Horton, M.D.

(317) 923-6990

1815 N. Capitol Avenue
Indianapolis, Indiana 46202

Diplomates, American Board
of Allergy & Immunology

Answering Service 926-3466

CARDIOLOGY

William K. Nasser, M.D. and Michael L. Smith, M.D. are pleased to announce the addition of Cass A. Pinkerton, M.D. for the practice of cardiology and cardiac catheterization.

8402 Harcourt Road, Room 413
St. Vincent's Professional Building
Indianapolis — (317) 257-9316

COLON AND RECTAL SURGERY

VINCENT C. SCUZZO, M.D., F.A.C.S.

Certified: American Board of Colon and Rectal Surgery
Associate Fellow: American Society of Colon and Rectal Surgeons
Specializing in Colon and Rectal Surgery

214 Sherland Building
105 East Jefferson Blvd.

South Bend, Ind. 46601

OBITUARIES

Harry S. Feinn, M.D.

Dr. Feinn, 66, a LaPorte otorhinolaryngologist, died Sept. 18 in San Bernadino, Calif., where he was attending the Ear Research Clinic.

He was a 1937 graduate of Loyola University School of Medicine. He was a Fellow of the American College of Surgeons and was certified by the American Board of Ophthalmology.

His family has established the Dr. Harry S. Feinn Living Memorial. Donations, being handled by the First National Bank & Trust Co. of LaPorte, will be used for medical purposes, education and charity.

Alan L. Sparks, M.D.

Dr. Sparks, 76, an Indianapolis otorhinolaryngologist, died Oct. 18 at St. Vincent Hospital.

A 1925 graduate of Indiana University School of Medicine, he practiced until his retirement in 1971. He was on the staff of several Indianapolis hospitals.

Dr. Sparks was a member of the American Academy of Ophthalmology and Otolaryngology, the American College of Surgeons and the International College of Surgeons. He was inducted into the 50-Year Club three years ago.

Clarence E. Sherwood, M.D.

Dr. Sherwood, 86, a former Allen County specialist in pulmonary diseases who moved to Brookings, S.D. in 1962, died in July.

He was a 1919 graduate of the University of Michigan School of Medicine.

Dr. Sherwood became a member of the 50-Year Club in 1969.

David Hadley, M.D.

Dr. Hadley, 64, an orthopedic surgeon in Indianapolis since 1948, died Oct. 19 in his home.

A 1940 graduate of Indiana University School of Medicine, he was certified by the American Board of Orthopaedic Surgery. He was on the staffs of several Indianapolis hospitals and was a clinical professor of orthopedic surgery at the I.U. School of Medicine.

Dr. Hadley, a former president of the Marion County Medical Society, twice was named Methodist Hospital's Distinguished Teacher of the Year.

**Road & Track just named
the 10 best cars for a
changed world.*
3 of those
names are...**



GIGANTI

INC.

VOLKSWAGEN
PORSCHE
AUDI

6901 East 38th Street
Indianapolis, Indiana 46226
(317) 545-4211



*Road & Track June 1978

The 1978 Convention



LUNCH AT POOLSIDE
Marriott Inn,
Clarksville



The ISMA Registration Desk signed in 475 member physicians and 381 guests for the 1978 annual convention, held in Clarksville in October.

Dr. Paul W. Holtzman, left, chats with Dr. Harold M. Manifold, his successor as trustee, Second District. Dr. Holtzman has been elected chairman of the ISMA Executive Committee.



Dr. Eli Goodman, right, congratulates new members of the 50-Year Club. They are, from left, Doctors Mathias S. Mount, William E. Pearson, John T. Emhardt, Harold S. Brubaker, John S. Huoni, Ralph H. Young and Leander

A. Malone. 31 other ISMA members also were inducted into the 50-Year Club. The names of all new members appear in the September 1978 issue of The Journal.



Many conventioners enjoyed an evening aboard the Belle of Louisville, above, including Dr. and Mrs. Donald W. Hunsberger of Montpelier, below. The Belle, which cruises regularly along the Ohio River, is the last authentic sternwheel steamboat in America.



No, this wasn't a scene aboard the Belle of Louisville. Rather, it was a demonstration given during the Basic CPR Course presented at the meeting of the Section on Emergency Medicine.





Seated at the head table during the annual President's Dinner were, from left, Rev. Patrick M. Commons, Charlestown, Dr. and Mrs. G. Beach Gattman (Mrs. Gattman is president of the Auxiliary), Dr. Lowell H. Steen (AMA trustee), Dr. Hoyt D. Gardner (AMA president-elect), and Mrs. and Dr. Eli Goodman, immediate past president.

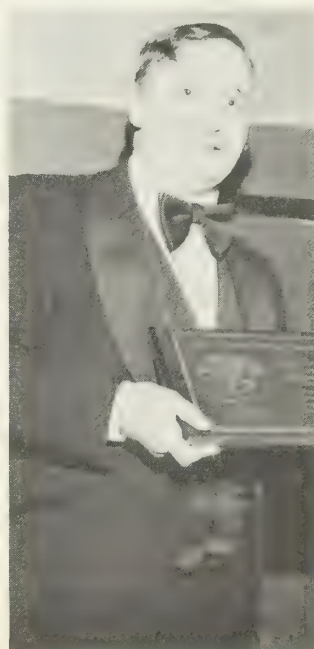


Entertainer Patrice Munsel, star of grand opera, concert stage, musical theater and television, performs during the President's Dinner.



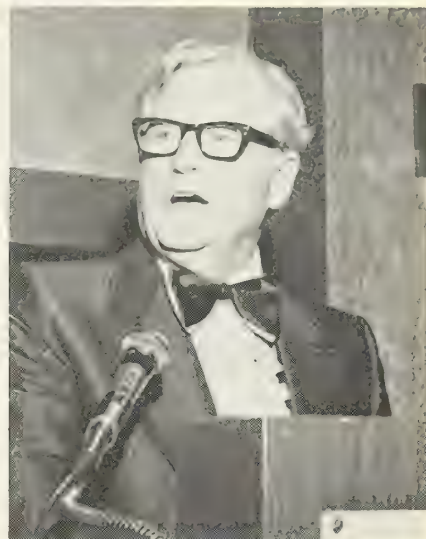
Dr. Thomas O. Middleton, a Bloomington pediatrician, accepts the annual "Physician Community Service Award" from Dr. Goodman. The award is sponsored each year by the A. H. Robins Pharmaceutical Company.

O'Ryan Rickard, editor of the *Rennselaer Republican*, below, received ISMA's annual Journalism Award in the print media category, while Marilyn Moran of WKJG-TV, Fort Wayne, received the award in the broadcast media category.





Head table (continued). From left, Governor and Mrs. Otis R. Bowen, M.D., Dr. James A. Harshman (newly installed ISMA president), Mrs. Harshman, Rabbi and Mrs. Leonard Devine, Louisville, and Dr. John S. Huoni (presented the 50-Year Club response).



Indiana Governor Otis R. Bowen, M.D., above, addresses a packed house of ISMA members, spouses and guests during the President's Dinner.

Dr. Goodman, left, receives an "Award of Honor" commemorating his year as president of ISMA from his successor, Dr. James A. Harshman, Kokomo.



Dr. Goodman discusses a last-minute arrangement before the President's Dinner with Donald F. Foy, ISMA executive director.



Dr. Harshman, left, chats with Dr. Hoyt D. Gardner, AMA president-elect, during the President's Reception.



During one of the lighter moments of the final meeting of the House of Delegates are, from left, Dr. Lloyd L. Hill, speaker of the House, Dr. Lawrence Allen, vice speaker, Dr. Eli Goodman, immediate past president, and Dr. James A. Harshman, his successor.



Dr. Arvine G. Popplewell addresses the House after being chosen ISMA president-elect.



Dr. Harshman, left, and Dr. Goodman, center right, meet with the medical father-son team of Dr. James L. Mount, Bedford, center left, and his father, Dr. M. S. Mount of Bloomfield. Both father and son served as delegates from their respective counties during this year's House meeting.



Newly appointed officers and trustees of ISMA, above, are sworn in during the final meeting of the House of Delegates.





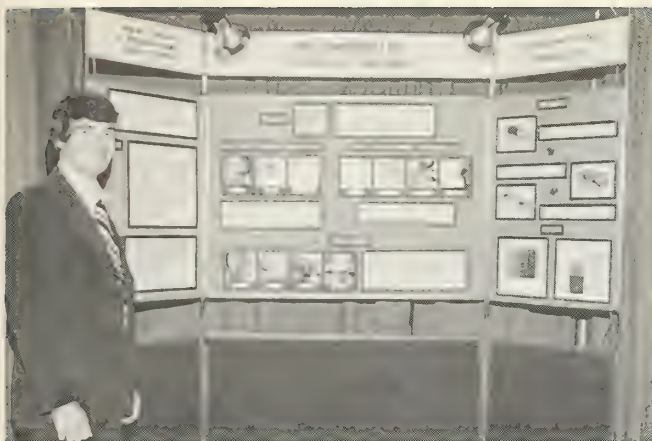
Dr. Goodman presents a corsage to Mrs. Ruth Gattman, president of the ISMA Auxiliary.

The Auxiliary held many planned activities during the convention, including meetings, tours and luncheons.



Members of the Auxiliary traveled to Louisville to visit such places as Churchill Downs and Wakefield Searce Galleries.

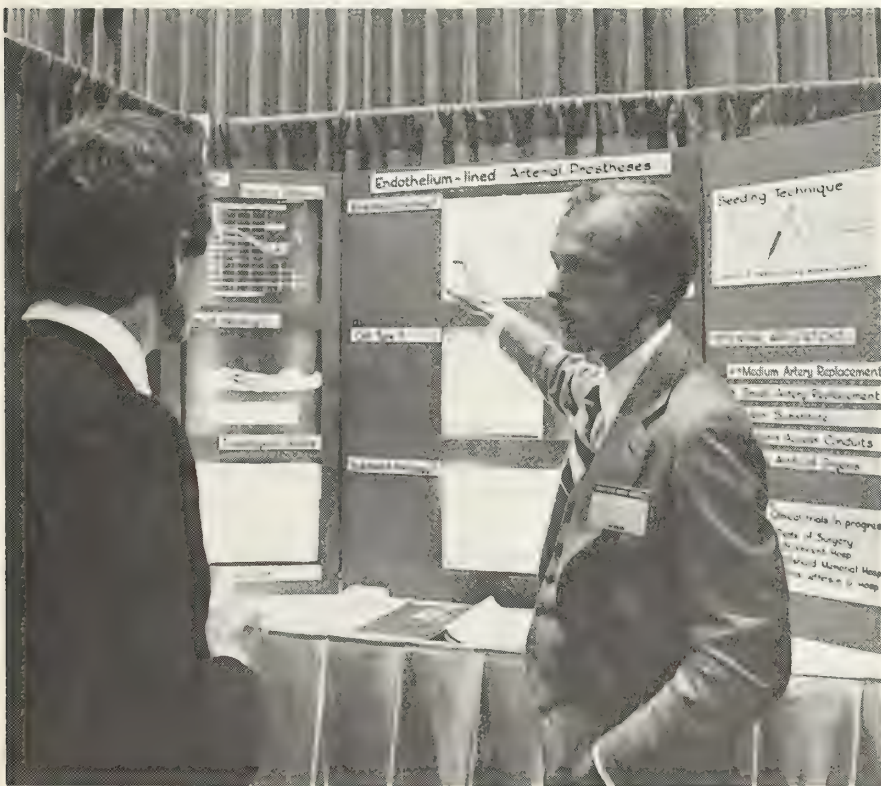




One of several scientific exhibits at this year's convention was "Mohs' Chemosurgery for the Treatment of Skin Cancer," above, exhibited by Dr. Philip L. Bailin, Cleveland, Ohio.



"Infant Scalp I.V.: A Teaching Simulator" was exhibited by Dr. Robert D'Agostino, left, and Dr. William L. Hildebrand, Indianapolis.



"Endothelium-lined Arterial Prostheses," left, was exhibited by Dr. Malcolm Herring of Indianapolis. Dozens of technical exhibitors were also on hand for the convention.

129th Annual Convention

Proceedings of the House of Delegates

Indiana State Medical Association

October 22, 25, 1978

Clarksville, Indiana

CALL TO ORDER AND MISCELLANEOUS	REPORTS OF OFFICERS
BUSINESS .....1171	Executive Director .....1182
IN MEMORIAM .....1171	Chairman, Board of Trustees .....1183
APPROVAL OF MINUTES .....1171	Executive Committee .....1185
ELECTION OF AMA DELEGATES AND	Treasurer .....1186
ALTERNATE DELEGATES .....1171	Indiana Delegation to the AMA .....1187
ELECTION OF OFFICERS .....1171	Editor, The Journal .....1192
ELECTED/REELECTED TRUSTEES AND	REPORTS OF COMMISSIONS
ALTERNATES .....1172	Legislation .....1193
REFERENCE COMMITTEES OF THE	Medical Services .....1194
HOUSE OF DELEGATES .....1172	Medical Education .....1195
ADDRESS OF THE PRESIDENT .....1173	Public Relations .....1197
ADDRESS OF THE PRESIDENT-ELECT .....1176	Constitution and Bylaws .....1198
ADDRESS OF THE AMA PRESIDENT-ELECT .1177	REPORTS OF COMMITTEES
ADDRESS OF PRESIDENT, ISMA AUXILIARY 1180	Future Planning .....1203
ADDRESS OF CHAIRMAN, BLUE SHIELD BOARD	Grievance .....1203
Printed Report of Blue Shield Board	Medico-Legal Review .....1203
Chairman .....1181	Medical Education Fund .....1203
ADDRESS OF STUDENT COUNCIL DELE-	Arbitration and Negotiations .....1204
GATE .....1181	Impaired Physician .....1205
	REPORTS OF AD HOC COMMITTEES
	Improvement of Medical and Health Care
	in Jails .....1208
	Computer Tomography .....1208
	Immunizations .....1209
	Data Processing .....1209
	REPORTS OF TRUSTEES .....1211
	RESOLUTIONS .....1218
	FUTURE ANNUAL CONVENTIONS .....1225

Call to Order, Miscellaneous Business

The House of Delegates convened at the 129th Annual Convention at 3 p.m., Sunday, October 22, in the Grand Ballroom of the Marriott Inn, Clarksville. The final session of the House of Delegates convened at 9 a.m., Wednesday, October 25, in the Grand Ballroom of the Marriott Inn, Clarksville. Presiding at both sessions were Dr. Lloyd L. Hill, speaker of the House, assisted by Dr. Lawrence E. Allen, vice speaker. Dr. Lester Hoyt, Indianapolis, served as parliamentarian. Invocation was given by Dr. Malcolm Scamahorn, Pittsboro. Dr. John Knote, chairman of the Credentials Committee, reported a quorum for both sessions.

APPROVAL OF MINUTES

The proceedings of the 128th annual meeting of the House of Delegates held at the Indianapolis Hyatt Regency (October 23-26, 1977) and published in *THE JOURNAL* of the Indiana State Medical Association, December 1977, were approved.

IN MEMORIAM

Tribute was extended to members of the Indiana State Medical Association who have died since the 1977 session:

William E. Arbuckle, Indianapolis
Joseph T. Brock, New Castle
Walter L. Bruetsch, Santa Barbara, CA
Stanley W. Burwell, Muncie
Bob R. Cagle, New Palestine
Myron L. Curtner, Vincennes
Camilius B. DeMotte, Greenwood
James U. Dodds, Hartford City
Thomas G. Donovan, Evansville
Charles C. Du Bois, Warsaw
Marion J. Eaton, Lafayette
Francis Edwards, New Albany
Ralph V. Everly, Indianapolis
Ben Z. Firestein, South Bend
Clyde M. Fish, Douglas, MI
Jacob C. Fleischer, Munster
Ray T. Foster, New Castle
George J. Garceau, Indianapolis
Raymond G. Geick, Fort Branch
Raul L. C. Gonzalez, Pompano Beach, FL
Donn R. Gossom, Terre Haute
Alton C. Grorud, South Bend
Howard T. Hammel, Springville
Donald R. Hampshire, Indianapolis
Clarence M. Harless, Chesterton
Casper Harstad, Rockville
Thomas Horwitz, Indianapolis
Fordyce L. Howe, Fort Wayne
Arthur N. Jay, Indianapolis
Wesley P. Jolly, Richland
John F. Kerrigan, Michigan City
Robert M. LaSalle, Sr., Wabash
George F. Lawler, Bradenton, FL
Glen Ward Lee, Richmond
Bernard A. Mason, South Bend

ELECTION OF AMA DELEGATES, ALTERNATE DELEGATES

The following were elected to two-year terms as delegates and alternate delegates to the American Medical Association, their terms to expire December 31, 1980:

Delegates: James A. Harshman, Kokomo; Malcolm O. Scamahorn, Pittsboro; Ross L. Egger, Daleville.

Alternates: Robert M. Seibel, Nashville; Everett E. Bickers, Floyds Knobs; Gilbert M. Wilhelmus, Evansville.

ELECTION OF OFFICERS

Dr. James A. Harshman, Kokomo, assumed the office of president and Dr. Arvine G. Popplewell, Indianapolis, was elected president-elect. Dr. Joseph F. Ferrara, Franklin, was elected treasurer; Dr. Douglas H. White, Indianapolis, was elected assistant treasurer. Dr. Alvin J. Haley, Fort Wayne, was elected chairman of the Board of Trustees. Doctors Paul W. Holtzman, Bloomington, and John W. Beeler, Indianapolis, were

Russell C. Mathewson, Muncie
William McBride, Valparaiso
Stanley M. McClure, Monticello
Roy R. McCoy, Fort Wayne
James S. McElroy, New Castle
Harvey N. Middleton, Indianapolis
John B. Mitchell, Evansville
Rollin H. Moser, Indianapolis
Jackson W. Modisett, Madison
Leonard L. Nesbit, Anderson
Milton H. Omstead, Petersburg
Thomas B. Pauszek, South Bend
Bertrand H. Pulskamp, Wolcottville
Alexander W. Rhind, Hammond
Virgil Scheurich, Oxford
Richard J. Schulfer, Hammond
Joseph Shapiro, East Chicago
Okla W. Sicks, Indianapolis
Norman M. Silverman, Terre Haute
John K. Spears, Paoli
Walter R. Springstun, Evansville
Robert E. Sullivan, East Chicago
John R. Swan, Indianapolis
Victor A. Teixler, Indianapolis
Harold C. Thornton, Indianapolis
George A. Tiley, Greenwood
William R. Tindall, Shelbyville
Harry E. Voyles, New Albany
James A. Waggener, Indianapolis (Honorary)
Elmer L. Wallace, New Albany
Paul A. Walter, Evansville
James W. Ward, Pompano Beach, FL
Robert K. Webster, Brazil
Donald G. White, South Bend
Fielding P. Williams, Huntingburg
Opal L. Wood, Brazil
Cecil S. Wright, Anderson
Byron K. Zaring, Columbus

Elections

elected at large members of the Executive Committee. Dr. Holtzman was later elected chairman of the Executive Committee. Dr. Lloyd L. Hill, Peru, was reelected speaker of the House of Delegates and Dr. Lawrence E. Allen, Anderson, was reelected vice speaker of the House of Delegates.

ELECTED/REELECTED TRUSTEES, ALTERNATES

District	Trustee	Alternate Trustee
1	John A. Bizal, M.D.	E. DeVerre Gourieux, M.D.
2	Harold Manifold, M.D.	Edgar R. Cantwell, M.D.

3	Thomas A. Neathamer, M.D.	Richard G. Huber, M.D.
4	Howard C. Jackson, M.D.	Mark M. Bevers, M.D.
5	Paul Siebenmorgen, M.D.	William G. Bannon, M.D.
	Davis W. Ellis, M.D.	Dan W. Hibner, M.D.
6	Donald McCallum, M.D.	I. E. Michael, M.D.
7	John G. Pantzer, M.D.	Gerald Kurlander, M.D.
8	Jack M. Walker, M.D.	Ted S. Doles, M.D.
9	John A. Knote, M.D.	Max N. Hoffman, M.D.
10	Martin J. O'Neill, M.D.	Leonard W. Neal, M.D.
11	Herbert C. Khalouf, M.D.	Frederick Poehler, M.D.
12	Alvin J. Haley, M.D.	Franklin A. Bryan, M.D.
13	Donald S. Chamberlain, M.D.	John W. Luce, M.D.

Reference Committees

REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Thomas C. Tyrrell, Hammond (Lake)
Richard A. Brickley, Indianapolis (Marion)
L. Ray Stewart, Evansville (Vanderburgh)
Fred W. Dahling, New Haven (Allen)
Davis W. Ellis, Rushville (Rush)

REFERENCE COMMITTEE NO. 1

Thomas C. Tyrrell, Hammond (Lake), Chairman
Nicholas L. Polite, Whiting (Lake)
Joseph W. Young, Greenwood (Johnson)
Douglas H. White, Indianapolis (Marion)
Richard Schaphorst, Mishawaka (St. Joseph)
John B. Guttman, Wakarusa (Elkhart)

REFERENCE COMMITTEE NO. 2

Richard A. Brickley, Indianapolis (Marion), Chairman
G. Beach Gattman, Elkhart (Elkhart)
Paul E. Humphrey, Terre Haute (Vigo)
Henry W. Conrad, Lawrenceburg (Dearborn-Ohio)
Charles D. Egnatz, Schererville (Lake)
Charles H. Aust, Fort Wayne (Allen)

REFERENCE COMMITTEE NO. 3

L. Ray Stewart, Evansville (Vanderburgh), Chairman
Shirley T. Khalouf, Marion (Grant)
Leonard W. Neal, Munster (Lake)
Charles W. McClary, Bloomington (Owen-Monroe)
Paul F. Muller, Indianapolis (Marion)
Gilbert Gutwein, Lafayette (Tippecanoe)

REFERENCE COMMITTEE NO. 4

Fred W. Dahling, New Haven (Allen), Chairman
George H. Rawls, Indianapolis (Marion)

Peter E. Gutierrez, Crown Point (Lake)
Kenneth L. Gray, Indianapolis (Marion)
George T. Lukemeyer, Indianapolis (Marion)
George M. Underwood, Lafayette (Tippecanoe)

REFERENCE COMMITTEE NO. 5

Davis W. Ellis, Rushville (Rush), Chairman
Helen G. Czenkusch, Indianapolis (Marion)
Max N. Hoffman, Covington (Fountain-Warren)
Beverly T. Maxam, Indianapolis (Marion)
Lee F. Dupler, Frankfort (Clinton)
Michael O. Mellinger, LaGrange (LaGrange)

SPECIAL REFERENCE COMMITTEE ON AMA/ ISMA RELATIONS

Peter R. Petrich, Attica (Fountain-Warren), Chairman
Patrick J. V. Corcoran, Evansville (Vanderburgh)
C. David Ryan, Columbus (Bartholomew-Brown)
Thomas G. Hamilton, Columbia City (Whitley)
Robert J. Bills, Gary (Lake)
Jack W. Higgins, Kokomo (Howard)

CREDENTIALS COMMITTEE

John Knote, M.D., Lafayette, Chairman
Cleon M. Schauwecker, M.D., Greencastle
Howard C. Jackson, M.D., Madison
Alvin J. Haley, M.D., Fort Wayne
Robert M. Brown, M.D., Marion

TELLERS

Robert Oehler, M.D., Brazil
William VanNess, II, M.D., Summitville
John Luce, M.D., Michigan City
Walfred Nelson, M.D., Gary

Address of the President

ADDRESS OF THE PRESIDENT

Eli Goodman, M.D.

ACTION: Filed and that the study in regard to IMPAC Board membership be referred to the Board of Trustees.

At the outset, let me welcome you to this corner of southeastern Indiana. As you probably all know, this is my home area. I've lived here a long time. If any of you want any suggestions about a place to eat, events, or what have you, feel free to come to me on a one-to-one basis and I'll help all that I can.

What I would like to do is sit down and chat with you about my stewardship of the trust that you placed in me one year ago. Believe me, I've been in political medicine for many years and I thought I had some understanding of the responsibilities of serving as your leader. But I have learned an awful lot this year and I have some concerns, I have some recommendations, I have some simple observations, and maybe a few prognostications.

Well, it's been kind of a long year. There's been an awful lot of travel in this year. I've been up and down the state, back and forth and crisscross. I've driven, I've been on commercial flights, I've had the distinct "pleasure" of making several flights on a mono plane, sometimes in good weather, sometimes in bad. At night I've often thought, "What have I done this day and where are we going?" So now I'm going to attempt to review my thinking with you.

The first thing that I want to talk about I have heard about each year since the enactment on October 30, 1972, of the very odious law that was championed by Senator Bennett of Utah, who described this piece of legislation as medicine's last chance to control the practice of medicine. I frankly to this day don't know whether he was right or wrong, but I have observed that, on the right, there is a group of physicians who in all good conscience and in all sincerity believe that the way to handle this particular project of PSRO is to turn our back to it and not engage with it in any way. Strangely enough, Ted Kennedy thinks that all of this should be turned away from and a physician should have no part of it. We have developed in Indiana seven so-called PSRO areas. This has been going on since about 1973 and 1974. We have taken many actions in this House about PSRO.

My observation as I travel around has been that, by and large, friends of organized medicine in the respective areas have tried to control PSRO, in good conscience believing that the way to fight it is to take part and interface with it. This is not universally so. We have at least one area where I thought I had a very clear recent demonstration that the PSRO was being controlled "by people not particularly friendly to organized medicine" and I will go into a little detail for

you now. My concern in my year as your President, knowing full well that this House has mandated that we not directly participate in PSRO as an organization, has been something that has come up on us I think largely since this House last met, and that is data. Under the PSRO law, if it survives—some people think that it will be funded maybe one or two more years and then it will go down the tube and if that's what happens fine—each PSRO must be provided by someone they select as a data provider with a discharge summary for each patient leaving the hospital; I don't know when this will be extended to the office or the long-term-care facility, but this discharge summary must have a minimum of 22 pieces of information which are then fed into a computer.

Now in 1973, this House of Delegates of the Indiana State Medical Association began its yearly review of how to relate to the whole PSRO problem and one of the things that happened was that we developed a not-for-profit organization which we named I-MEDIC, the Indiana Medical Education and Development Center. PSRO seemed to go into a period of dormancy, then in the last year or so it began to come to light again and we began to hear of the seven PSRO areas letting contracts for data controllers. Some of us in your leadership group began to look into this with varying reactions; my reaction was one of alarm. I felt that the data that could be obtained would place the medical records of our patients, the people of Indiana, in jeopardy of unwarranted disclosure. I further felt that the physicians of Indiana were being placed in great jeopardy because it is possible with this computer machinery to "massage" out information which ultimately could mean that perhaps your neighbor in an HSA down the pike who has some kind of a working relationship with the PSRO is going to say that you're a bad doctor or you're this or you're that.

So we activated very strongly our I-MEDIC corporation. We sought advice of legal counsel, we converted it on advice of legal counsel from a not-for-profit organization to a for-profit organization and we in your leadership or I, if I may be asked to take individual responsibility, felt that it was in the best interest of the people and the physicians of Indiana that we try to lock on to that data. Don Foy and I began to scurry across the country to see what was being done elsewhere. We found, for instance, that Colorado, with federal grants from Colorado State Medical Association, was provided the total PSRO package. We found that South Carolina was providing the total PSRO package using a foundation concept, as were Mississippi and several other states. We felt, I think rightly under the strength of our House of Delegates, that we did not want to be involved in the PSRO *per se*, but I felt that we should make every effort to control the data.

Address of the President

Again, there are seven PSROs. We began the process of submitting competitive bids to see if I-MEDIC, which is now a for-profit organization, might be selected by the PSROs as the data processor so that at the very least, the hands on the medical records of the people of Indiana would still be our organization. True, I don't think that's 100% foolproof, but I think it comes as close to being foolproof to the physicians and the patients as we can possibly get.

And now let me tell you what happened. I'm going to review for you the seven PSROs in the state of Indiana. I don't know the basis for this, but apparently the bureaucracy decided to discipline or punish one area and apparently they are in the process of losing their contract; I don't know if that area is going to appeal, and I don't know if there is any right of appeal, but I do know that if they lose the contract, the law says that the PSRO work may be done either by an adjoining PSRO which would undertake the contract to do it or by a fiscal intermediary. Area V, of whose board I am a member, somehow or other made a decision to award its contract to an organization called WPS which stands for Wisconsin Physician Service. Within that PSRO we began to make inquiries and we were told that Wisconsin Physician Service, based in Madison, Wisconsin, was the way to go. I was personally horrified. I couldn't imagine a situation in which all the medical records and all the data on physicians for the state of Indiana could be obtained out of a building in Madison, Wisconsin, completely out of our control; we got real busy.

Don and I went to Wisconsin and I refer now to Exhibit A. We met with the Executive Secretary of the Wisconsin State Medical Association and learned from him that, in fact, WPS was a Blue Shield plan. There's nothing wrong with it being a physician plan except that there are many people who have grave misgivings about any fiscal intermediary having any records, and I share that. Then Mr. Thayer up at Wisconsin was good enough to furnish us with a copy of the minutes of the preceding meeting of the House of Delegates of the Wisconsin State Medical Association and I want to read you one or two sentences: This is a counsel at its meeting of August 6, 1977, appealing to WPS to provide certain evidences of a desire to maintain and expand good faith relationships with the state medical society. These appeals have never been acknowledged.

With that kind of information, of course, Don and I came back certain that we needed to fight to prevent the data on patients in Indiana getting into the control of these people and so we went on with our bids. Area V was the first area; this is an area which extends from Indianapolis down to the Ohio River, very well gerrymandered I guess, but that's what it is, and Area V indicated that it would award its contract to I-MEDIC.

Two other areas rather quickly indicated they wanted their data to go to I-MEDIC. One area, and this has to be the area I referred to before despite an appeal from me that they were moving in a direction of placing the data of their patients and themselves in the hands of unfriendly people, has already awarded its contract to WPS of Wisconsin.

Now then, a strange thing happened. We began to have our contracts being approved for I-MEDIC to control this data and, lo and behold, HEW in Chicago sent us a letter which said, in effect, no soap boys, you're not going to handle that. It offered a number of reasons why I-MEDIC, a for-profit subsidiary of ISMA, was not in their thinking a good candidate. We reviewed their commentaries. We had telephone conversations with them which were unsatisfactory. About a week or ten days ago, I called the office of the senior Senator from Indiana who responded to my requests that a conference or hearing be set up that would involve HEW, Area V and his office. This took place five days ago, and I read you now Exhibit A. This is a letter from the Health, Education and Welfare Division of PSRO. This is a short letter and I want to read it to you in its entirety. It's addressed to Dr. Charles L. Thomas, who is sitting up here and who is chair-person of the Area V PSRO.

"Dear Dr. Thomas: We have reviewed the information in your letter dated October 18, 1978, and this was a letter we composed in that conference, concerning our rejection of the I-MEDIC proposal. After our review, we feel that the information provided satisfactorily responds to our concerns. We are recommending approval of the proposed subcontract with I-MEDIC to the contracting officer in the contract operations branch in Rockville, Maryland. Final approval of the subcontract is the responsibility of that office. Should you have any questions concerning this matter, please contact me."

A complete reversal, and I don't want to go into why. I just want to tell you that your leadership struggled with this thing and, as of today, we have for I-MEDIC four areas that have either signed the contract or indicated they will. It has become valuable and I would say important to the Indiana State Medical Association to have at its disposal, because of the multitude of changes in the tax structure, because of all the inquiries that are made, and because of all the agencies that descend on our office to look at our books, that we now must have a for-profit subsidiary which we do have.

Gentlemen and ladies, this was the principal thing I wanted to deliver to you. I know I have taken a lot of time but if you'll bear with me a few more minutes, I'd like to hit some of the other things that have happened this year which I think are significant. For example,

Address of the President

we have had to deal with the mushrooming of HSAs and, somehow or other, either through actions of the HSA or through the busyness of the average physician, we just simply are not getting the representation on the HSAs. As a result, those people are deciding how we're going to practice medicine, where we're going to practice it and how much we're going to get for it. I can only urge everyone in this room to become knowledgeable of the HSA in the area in which you live. Try to get into it. Many of you, like myself, are in the past-39 age bracket. If you feel that you don't have time to get into it, see if you have a young colleague who might get into it. I think it might be an awfully good starting point for a younger physician to begin to learn something about practical politics of medicine when he deals with the butcher, the baker and the candlestick maker who are making all of the decisions for him.

I will report one other thing to you in connection with HSAs. Some physicians feel that an individual is improperly seated on the board of the southern HSA, and a law suit has been filed. I think the effort to see to it that the HSAs serve the public and serve them legally is not arbitrary and capricious. One HSA in California was recently disbanded because of loss of a lot of money.

Enough of that. I think most everyone is aware of the big fiasco we had last year about the national planning guidelines that would have shut down about half the hospitals in the state of Indiana and about two-thirds of the obstetrical departments. Well that ballgame isn't over yet. Mr. Califano is still rigging up new things that he's going to bring to you. And you ought to try to be knowledgeable. At the federal level, last week was real chaos. The Congress decided that they wanted to close up and go home and campaign for reelection. Some of the people unfriendly to medicine took everything that we don't like, every last one of them, and tacked them on to bills here and there. Notably, a cost containment bill was tacked on to the Tariff bill.

I want to say something about IMPAC, our political action group. It's not getting the support it needs and I don't know why, but I have a reaction or two that I'm going to state very openly. When I became very knowledgeable about IMPAC some ten, twelve, fifteen years ago, they had a problem of it being considered an appendage of one of the political parties. Some of us worked very hard to erase that image that number 1 we raise money, number 2 we gave money to candidates who shared our philosophies and who we thought would be able to win. But we injected another item; we made some donations to people on a basis of maintaining lines of communication. I see that reversing itself again. I think we're moving back toward an appendage toward one political party and I'd like for

everyone to think very strongly about perhaps restructuring IMPAC just a little bit . . . I'm not sure how, perhaps it ought to be half Republican and half Democrat or perhaps it ought to be proportionate to whatever the state political population is.

A word about the voluntary effort which they tried to knock on the head last Saturday night. I happen to chair a statewide voluntary effort that is made up of a group of very distinguished people. We've been very fortunate to get leaders in labor, industry, management to join with us and so far we have had four meetings. I recently attended a meeting in Cleveland, Ohio, at which there was an intense analysis made of where we are. In a couple of weeks I'm going to New Orleans to another sub-meeting because I think we're down to the point in the voluntary effort where we need to name names and call things. Everyone is just a little reluctant to move into that.

I want to say a word about our journal. The September issue of *THE JOURNAL* came to me early and it had in it pretty much a beautiful set of reports from the committees, the commissions, the treasurer, the chairman of the board, and I just thought it was very well done.

Our committee on impaired physicians has done a great job and we're going to have a program at 3:00 Monday afternoon. They have published a pamphlet which I think is excellent. I hope you'll all try to get one and read it.

Our negotiations committee—I think it's fantastic—for the very first time I know of in the state of Indiana under the leadership of Al Haley, was invited to review a proposed contract between labor and management before it went into effect. That's never happened before to my knowledge.

A word about our housekeeping. You know your headquarters staff, which I think is magnificent, has taken on more and more duties for more and more of us, and they're bulging at the seams. They're just simply going to have to have more space. If I-MEDIC actually carries out the data processing thing, and I think it will, we're going to need more space. Just for your information, I will tell you that your leadership has been intensively studying our building, we've been studying reports of comparative costs or renting versus owning, we're looking at nearby property and I know something will have to give there.

A word about professional liability. Looks good, but it's not settled yet. There are currently two cases that have been moved directly into the Supreme Court of the state of Indiana. Everything we know so far would seem to indicate that our professional liability law will finally be declared legal.

Concerning district medical society meetings, I attended all but one. I managed to have some kind of flu

Address of the President

for one of them, but something needs to be done there. Attendance at district medical society meetings across the entire state—the big areas and the small areas—is not what it should be. I'm not sure how that can be changed, but it needs to be changed. One other thing about the district meetings. I took the liberty earlier in my tenure of sending to each district a suggested agenda of the conduct of the meeting. In this agenda, I was very particular to see to it that there would be a demand made that the members of the various commissions and committees from the respective districts

would be required, asked at least, to give a report to their district at that meeting about what is going on at the state level. This was done in some districts—I think it helped—it was not done in others.

Lastly, I want to tell you that in my stewardship for you one of the things I have done—and this has been very pleasant—has been to appear for you on a number of television shows. I've also made several radio talks, given newspaper interviews, and made several trips to Washington to talk with the people there. In general, I have tried to do my best for you.

Address of the President-Elect

ADDRESS OF THE PRESIDENT-ELECT

James A. Harshman, M.D.

ACTION: Referred to the Board of Trustees.

In the few minutes that have been allotted to me, I would like to briefly discuss a plan of action which I believe the Association must undertake if we as a professional association are to survive.

Last spring I met with the Future Planning Committee and requested that they, in cooperation with the officers and staff, develop goals and objectives for the Association. This is the first time, that I am aware of, that the Association has attempted to develop a plan for the future—a plan to which we could direct our limited resources.

I am happy to report that Dr. Stanley Chernish and his Future Planning Committee took this charge seriously and developed a comprehensive program of work for the future. This report is in your handbook as a supplemental report from the Future Planning Committee to this House. I hope you will read it carefully, discuss it at the Reference Committee, change it as you see fit, and adopt it, to give your officers and staff a sense of direction for the coming year.

In the near future organized medicine will receive its most severe challenge of the century. There are those in the federal government who would like to see the profession destroyed. Every year the Association has to respond to inquiries from some federal agency. Federal regulations from HEW, SSA, FDA and other federal agencies are endless. To respond to this proliferation of federalism, it is imperative that ISMA strengthen its organizational structure from within and better control its own limited resources. Indeed, this is one of the primary goals as identified by the Future Planning Committee.

Some of the objectives under this goal are as follows:

1) Our reserves must be adequate. Currently, the Association is in excellent financial condition. Poten-

tial litigation could rapidly deplete the Association's reserves. We need to explore the development of outside sources of income in addition to that received from dues.

2) All of our programs should be re-evaluated periodically to make certain that they are fulfilling their original intent. One of the most important of these programs is our computer program. We must continue to develop this program to assist in membership activities, political activities, and to assume a major role in data collection and storage in the best interests of organized medicine.

3) We must improve our communications to our members as well as to the public. I hope to personally visit as many county medical societies as possible this coming year. Howard Grindstaff has agreed to escort me to any society that offers an invitation. I hope to accept as many invitations as possible, providing all meetings do not occur on a Tuesday night. I know the other officers and trustees will assist me in this personal type of communications this coming year. Our relationship with component societies and the specialty societies, as well as other health related associations, must be strengthened.

4) ISMA must continue to develop skills in negotiations and assume an aggressive role in negotiations on behalf of our members. I am pleased to report to you that our Negotiations Committee, which this House formed last year, has made excellent progress. Their role will become more and more apparent in years to come.

I am confident our Association can be strengthened through these objectives to meet forthcoming challenges.

Finally, one of the most important goals to be established by this Association is to improve and strengthen our activities in dealing with state and federal legislation and governmental agencies. A little more than a week ago the 95th Congress adjourned. A

Address of the President-Elect

large number of bills dealing with medically related issues died in the waning moments of a session that produced a tax cut without a cut in federal spending, and a so-called energy bill. Cost containment legislation, Medicare/Medicaid reform, health planning amendments, and compulsory national health insurance all died. You can be assured that all of these issues will resurface again as soon as the 96th Congress is convened in January.

The Carter Administration has already indicated that two of its top priority legislative issues will be cost containment and compulsory national health insurance. Senator Kennedy has already taken his familiar "dog and pony show" on the road in the form of NHI hearings. With the tax and energy bills out of the way, we can expect the administration to apply greater pressure than ever for cost containment and compulsory national health insurance.

Let me make it perfectly clear that physicians are in favor of voluntary cost containment, but we are opposed to federally imposed caps and wage-price controls. The voluntary effort to contain costs is working well. Following the last federally mandated wage-price control of 1973, costs escalated rapidly, as they always do when the economy is allowed to return to a normal supply-demand situation. For the past four years the rate of increase of health care costs has gradually decreased to the current rate of 12½% a year—a rate that is only slightly higher than the rate of inflation.

So desperate was the administration in the last hours of the Congress to pass federally imposed caps, that the Senate tacked an amendment on a previously passed House version of a tariff bill in order to get something on the books on cost containment. The efforts of the AMA in exposing the deceit of the Senate were successful, and the House wisely refused to pass a bill that contained a major amendment they had never seen.

If the administration is really serious about cost containment, they should direct their attention to the

real culprit—inflation—rather than to point a finger at a single industry as the bad guy. This and previous administrations have tinkered with every conceivable control and economic indicator to contain costs. They have all failed to recognize the two most important contributors to inflation—federal agency regulations and deficit spending by the federal government. I have been to Washington a half dozen times this past year, and I have been amazed at the refusal of our elected federal officials and federal agency officials to admit that *they are the problem*. Strangely, they only see themselves as the solution.

How are we going to affect the situation?

1) I would hope that we would quickly institute a keyman program. Congressmen need to hear from hometown people directly and often. A week ago Friday, it was necessary to contact the entire Indiana congressional delegation on an important piece of legislation. In those instances in which the hometown doctor made the call, immediate contact was made with the congressman. In all other instances, the Association was only able to contact the legislative assistants.

2) We should keep a tabulation of the voting records on health issues for each congressman.

3) IMPAC must be strengthened and coordinated with the Association's legislative activities.

4) We must increase the surveillance of government agencies and their intrusion into the practice of medicine.

5) ISMA should submit its comments and opinions to congressional hearings and to the Indiana congressional delegation to make certain our position is known. Comments must be submitted to the federal agencies on regulations as they are published in the Federal Register. We cannot afford to be silent or apathetic on issues that affect us and our patients.

The threats that have been leveled at our profession are great; the challenge to protect our freedoms is even greater. With your direction and help, we can meet them.

Address of the AMA President-Elect

ADDRESS OF AMA PRESIDENT-ELECT

Hoyt D. Gardner, M.D.

ACTION: Filed.

It is a great pleasure to bring you greetings from the American Medical Association and from Kentucky, your neighbors from the south . . .

There always comes a time of self-assessment, times of evaluation, times of exchange of information which is pertinent. In these few moments I would like to talk to you about the American Medical Association. But

first I would like to speak to you about what medicine is in this country today.

What is medicine in this country today? An astonishing panorama display of figures. There are 400,000 physicians in this country; 80,000 are foreign medical graduates. There are 7,000 hospitals in the United States with 3,250,000 employees. We perform 18,000,000 operations a year, have 2,000,000 daily visits in our offices, and write 6,000,000 prescriptions daily. There are 34,000,000 hospital admissions per year. There are 124 medical schools with a composition of

Address of the AMA President-Elect

56,000 students—18,000 graduates per year. There are 40,000 physicians in postgraduate education. From all of this display of physician brainpower, manpower, etc. comes 2,000,000 scientific publications and articles a year, 200,000 scientific research projects, 5,000 new drugs and appliances each year and 1,000 new technical procedures. All of this together generates \$180,000,000,000 in the gross national product, making medicine the second or third largest industry in the country.

Now let's talk about what the American Medical Association is in all of this. It is composed, as you know, of the confederation of states; the headquarters is in Chicago at 535 N. Dearborn; it is 139 years old. It has had 133 presidents. There are 175,000 active members, governed by a House of Delegates composed of 270 members, five of whom as you know are from Indiana. The custodial direction of the AMA rests in between two meetings annually of the House and the 15-member Board of Trustees, 12 of whom are elected; the other three are the president-elect, the president and immediate past-president. At this headquarters there are 950 employees, administered by an executive vice-president, one assistant executive vice-president and three assistant vice-presidents. It has an annual budget of \$64,000,000 and 85% of this budget is spent on the betterment of the profession and the betterment of people's health. 85% of the 64 million dollars is spent in this matter.

What else is the American Medical Association? The largest publisher of scientific material in the world. There are 26 major publications each year. It is the largest private public newspaper in history. It is the second largest medical library in the world, the largest being the Armed Forces Institute. It has its own computer capacity, equivallency to HEW, and I think you understand that. HEW seems to have a curiosity in recent years. You put certain figures in and they come out with unusual inaccuracies, as high as 64%, when they were dealing with Medicare. Some people say why do you need a computer capacity that large. That's one of the reasons we need it. It seems as though our information comes out differently. It is necessary and important anymore when you find out there are transgressions that prevail in the public bureaucracy that have to be watched over that you have equal possibilities. We have that now at a cost of \$7,000,000 on your behalf and the behalf of our patients that accuracy be exposed in bureaucracy as well as in the operating room, and the hospital corridor and your office.

There are 51 specialty associations under the broad umbrella of the American Medical Association, and each of these 51 have a delegate and alternate delegate in the House.

What else is the American Medical Association? It accredits, singly or jointly, all of the hospitals in the country, all 124 medical schools, all of the post graduate medical education. There are over 700 continuing medical education programs in this country every year. It accredits also all the ancillary medical facilities, ambulatory care facilities, health care centers of various types. All of this gives me the distinction of professionalism, of competence, of expose' of expertise to the public. This is all done at the national level.

In addition, through association with the World Medical Association, we maintain activities with 141 other countries throughout the world who have joined the heart of this profession to extend its hands to our afflicted or ill or ill-served abroad as well as at home. There is a continual panorama of people, of communications that flow through the 535 offices every day from abroad that we respond to. One other thing, the American Medical Association is the most widely circularized and publicized profession in the history of the world. Yet one of the criticisms that you hear from our colleagues, yours and mine, is that nobody tells me what is going on. Now we have to re-examine ourselves when we make that kind of allegation. When you are the most widely circularized profession in the world, and a guy doesn't know what is going on, there is something at fault here. It takes two things for communication. One is sending and the other is receiving. It makes no difference the efficiency of sending, if it is not being paid attention to. Now we are challenged at the grass roots today, all of us, to be more receptive to this exposure from your national association. If you say nobody is telling me what is going on, it means that you are not paying much attention, because you are circularized, you are exposed. You have 700 meetings a year in this country. You have 700 post-graduate courses you can attend. You have the largest private newspaper, 26 major publications, all the things that are generated at the state and county. You are exposed.

What about the conscience of this profession? The Judicial Council elected by the House of Delegates is advised to meet continuously as the conscience of our profession and also acts as an opportunity for those who have disagreements at the county or state level to be adjudicated by their peers. It is a court of last resort, but an opportunity also.

Finally, let's talk about organized medicine itself. It is composed of three parts. They are indivisible, yet they are entirely separate. The county does one thing at one strata, the state does another and then the American Medical Association is the broad umbrella that speaks nationally and internationally. They are inseparable; they cannot distinctly or separately exist apart. They have individual responsibilities, but together they bring the cohesiveness that gives us

Address of the AMA President-Elect

strength. Now I said, there are 400,000 of us in this country of which there are 175,000 active members in organized medicine. An obligation on each of us is to bring into the fold as responsible, reactive, sensitive physicians these other 225,000 members.

I'd like to talk to you in depth about some things going on in the world with other countries. Because now we are being confronted again by National Health Insurance, a politicized issue. As you have already heard, we are told we are insensitive, that we have failed, that cost is out of hand, that there is medical praxis in the country, that people can no longer afford your activities or mine, or the hospitals, or medical care generally. All demagoguery, because in the country, no citizen is concerned more than 19th on any list of priorities about challenges, or crisis in health care. But we must respond and we must react. For the national, state and county associations, it is a responsibility to react to demagoguery. There is no sacredness in the House or Senate. There is no particular confine that says their eruditeness in Massachusettes isn't exposed or known in the rest of the country. But it doesn't say that you can't be hypocritical when you want a domestic issue to thrust your ambitions. Keep it in mind. Do not forget, history has shown in every example where government gets control of health care, it becomes a budgetary hardship—leading to rationing, deficiency in supply, lack of research, lack of bricks and mortar, lack of quality institutions and finally, lack of quality people delivering that health care. There are examples all over the place. We've got them now rapidly coming toward us from Canada. Everybody wants to debate the issue today about Canada. Why not talk about England? In the days of Medicare and Medicaid, everyone wanted to talk about England. Nobody wants to talk about England today, because they have been found wanting. 43% of the domestic budget is spent on health care and yet you wait 18 months to two years to have a gall bladder operation and up to three years for a cataract operation. Up to two years for a hip joint. All of this because citizens have been deprived, and have lost the human rights to deal for themselves. And the opportunity to be their own people, because of bureaucracy and political hypocrisy. Since we are in the bulwark of the challenge, we must be responsive as we always have for this hypocrisy, demagoguery, falseness. It is not a speech that anyone alone can carry, all of us must. But we are particularly well equipped now. We have the computer, we have publications, we have the resources, we have the minds and we have the people. This time the profession will not be found wanting. And we are positive, we are significant and we do have the confidence of our people.

Let us speak a moment about the future, because this

profession is rapidly being thrust once again into an all-time challenge. Not the plague, but it can be more severe. Medicine, law, education and religion throughout history have been the four learned professions. And they have borne peculiar and unique responsibilities through civilization and today we are challenged on the basis, strangely enough, of professionalism. And you know about the FTC that says you are no better than a handyman, that you are no better than a plumber; they ignore all your responsibilities, all your education and all your histories, all your technologies, and the conscience and the profession. But you are challenged and I want to talk to you about that and I want to carry it a step further. It is rapidly becoming obvious that decisions must be made. And these can only be done by the people who are suited to do this, and it can only be done by consensus and collective voice. Civilization is turning to the four learned professions, medicine, law, education and religion, to lead them again out of the darkness over finite resources. And we are deeply involved, and I will tell you why. Cloning, test tube babies, Karen Quinlin examples. We have to respond to that. Hopelessly, criminally insane, the geriatrics have lost all quality of life, vegetating. What are we going to do? What will be the conscience of these decisions? What about abortions? What about the hopelessly malformed child that is brought into this world at a cost of five kids being sent to college every year. What is death? Who will decide? This profession and its conscience must be one of the four horsemen again to respond as a conscience to civilization. And you can only do this as a collective voice, and if you have no other responsibility, to be collectively organized together for a consensus, this is it. Civilization is calling again, rapidly, to deal with finite resources and particularly in the areas of human life and death that must come from the four learned professions, and it has to be done in a country of collective voices. Traditionally, this profession has never failed, and will not do it this time, but it has to be done collectively and through the American Medical Association our historical example will prevail. So I will tell you that your forces are strong, your leadership is ready, our grassroots must respond and history will look back in time, as we are sure to respond and say, "It was indeed this time that they have reached out and have again claimed, and handled, the life and the flame of greatness."

Address of the President, ISMA Auxiliary

ADDRESS OF PRESIDENT, ISMA AUXILIARY

Mrs. G. Beach Gattman

ACTION: Filed.

It is a distinct pleasure for me to have the opportunity to address such a distinguished group of people and to report on the status of the Auxiliary . . .

Fifty-one years ago when the Auxiliary was organized, its primary purpose was to assist the ISMA in its program for the advancement of medicine and public health. Today this is still our primary objective. We are proud to be an Auxiliary to the ISMA and we will assist you whenever and wherever possible. All new programs and projects that the state and county auxiliaries undertake should first receive your approval. If for some reason this is not occurring on the county level, there's been a communication breakdown, and I would suggest you take the first step to repair the damage.

As I've traveled to other states, I've become more aware of how fortunate the Auxiliary is in Indiana. The ISMA is to be especially commended for giving the Auxiliary so many avenues of communication with its members. Each month the Auxiliary President's page in *THE JOURNAL* contains information on various Auxiliary activities and functions. The Auxiliary president is also invited to attend each meeting of the Board of Trustees and to report on the Auxiliary. This speech is a yearly event. The Auxiliary, in turn, reciprocates, and together we're learning more about the activities of both organizations. Our communication on the state level is excellent. Does your county follow the example of the state? Why not try to establish better communication between the county medical society and auxiliary during the coming year? Both organizations will benefit, and you'll develop a greater appreciation for the work you're both doing.

Auxiliary membership has remained around 2,700 for the past several years; however, last year five county medical auxiliaries became inactive due to lack of members. In studying our membership figures, it's obvious that the larger counties are becoming larger while the smaller are becoming smaller. Our membership figures also reflect concern where the physician chooses not to belong to the medical society, thus making it impossible for his spouse to belong. Our goal this year is to invite each prospective member to join the Auxiliary and to organize county Auxiliaries wherever possible. I'm certain *your* spouse is an Auxiliary member. If not, we'll be happy to accept dues at the Auxiliary registration desk. If your county Auxiliary presently is not organized will you assist us as we work with the spouses of physicians in your area? There *is* strength in numbers. Join us, we can do more together!

The greatest activity in Auxiliary is occurring in the area of Health projects. Every imaginable health proj-

ect that exhibits concern for the health and well-being of others is being carried out by county Auxiliaries throughout Indiana. This is the area that enables the county medical society and the Auxiliary to work closely together. It provides an excellent opportunity for the Auxiliary to present the positive side of medicine to the public through good media coverage. We're grateful for your assistance and advice, especially in this area, as we help make our counties healthier and happier places in which to live.

In the spring of 1978 Governor Bowen informed the Auxiliary that he would like to designate us as the Lead Voluntary Action Committee in the area of Immunization for the state of Indiana. With the approval of the Board of Trustees of the ISMA and the board of the ISMA Auxiliary, our co-chairmen, Carolyn Moheban and Anne Throop, and myself began a series of meetings to learn specifically what our duties would be. We learned that first, the State Board of Health would be assisting us in this effort; second, the Immunization Action Committee would be serving in an advisory capacity to us; and third, our chief function would be to coordinate all activities in the area of immunization in Indiana. In our area of coordination, we will be doing the public relations for the Immunization Action Committee, thus presenting the true picture of immunization in our state.

Some of the facts we gathered at the recent Immunization Action Committee meeting are that the Indiana Association for the Retarded has made Immunization Awareness their top priority this year and stands ready to assist us in the 84 counties where they are organized. The P.T.A. has a packet of information ready for distribution to school-age children and the School Nurses Association will assist in this effort as needed. Specifically, we have been asked to assist in gathering data on the immunization levels of 8-12th grade students in school systems that have requested help. Presently there are no accurate statistics available in Indiana for this age group. We are working closely with Dr. Robert Parr, Immunization Chairman, ISMA, and will keep the Board of Trustees fully informed of our progress. We're certain the statistics will show that the physicians in Indiana have done an excellent job in the area of immunization. We hope the positive public relations generated by our activity in this area will stimulate those who have been remiss and will once again present the positive side of medicine to the public.

Anyone who worked on the Indiana Malpractice Legislation does not have to be convinced of the importance of the Auxiliary in the area of Legislation. This is an area where the Auxiliary excels and can be of great help to the ISMA. Our members are encouraged to become informed on medical legislation and to re-

Address of the President, ISMA Auxiliary

spond intelligently and effectively on specific issues when asked to do so by the AMA and the ISMA. We are also encouraged to become involved in the political process and support the candidates who will support medicine's views both individually and collectively through our time and money. If we can help stem the tide of federal legislation that restricts the practice of medicine all our efforts will be worthwhile. As Omar N. Bradley wrote, "If you will help run our government in the American way, then there will never be danger of our government running America in the wrong way."

One of the most tangible ways the Auxiliary shows their concern for the future of medicine is their support of AMA-ERF. The only un-designated funds Indiana University school of Medicine receives are the dollars contributed to AMA-ERF. For each dollar contributed to the student loan fund, \$12.50 can be loaned to a needy student. This year we are attempting to inform our membership about the need for these un-designated AMA-ERF funds and answer any questions that have arisen in the counties about the use of these funds in Indiana. We hope you will stop by the AMA-ERF booth at the convention and support this worthy cause. If you choose to make a special contribution in memory or in honor of a friend, consider making it through your county Auxiliary AMA-ERF chairman. We're anticipating an outstanding year for AMA-ERF in Indiana. It's our way to invest in medicine's future.

As we continue our work with SAMS—Spouses of American Medical Students—we are more convinced

than ever that the future of medicine is in good hands. These talented young gals bring a glow to every facet of life and serve as a reminder to us of what it's like to be married to a medical student. We're happy to see the Auxiliary at the Regional Medical School Campuses welcome the students to their community and offer to assist them wherever needed. It's one of the most pleasant jobs in Auxiliary.

The new format of the "Hoosier Doctor's Wife" has prompted much favorable comment. This is our chief method of communication with our members, and will be undergoing a name change in the near future to reflect our male members. Please do send in your suggestions for our new name to go with our new look.

"You've come a long way, baby" surely reflects the sentiments of Auxiliary during the past fifty years. With your support and encouragement the next fifty years will be more challenging and exciting than the first. A saying Beach and I recently saw in a store window expresses my feelings about Auxiliary. It read, "There are no strangers here, only friends who have not met."

Thank you for making this such a rewarding experience for me and for providing the Auxiliary with so much capable assistance and help. To Don Foy, Ken Bush, Rosanna Iler and the outstanding staff at the ISMA a sincere thank you for all you do to help make the Auxiliary run smoothly. We're proud of the outstanding work you do and privileged to work in partnership with the finest physicians anywhere.

Other Addresses

ADDRESS OF CHAIRMAN, BLUE SHIELD BOARD

Joseph Black, M.D.

ACTION: Filed.

A brief printed report is available in your packet concerning details of membership. Also at the convention you will find our staff of professional relations people here to help you with personal insurance problems. Since you are a member of Blue Shield and since you have been a member of the group since 1962, we are pleased to offer each delegate a cup as a memento of this convention.

PRINTED REPORT OF BLUE SHIELD BOARD CHAIRMAN

ACTION: Distributed and Filed.

ADDRESS OF STUDENT COUNCIL DELEGATE

Carl Otten

ACTION: Filed.

I am honored to speak here today. This year is my first time here. I am the delegate selected by the Student Council of the Indiana University School of Medicine, and am excited to be a medical student and to enter such a prestigious profession.

Today's medical students are highly aware of both the threat and the promise of government intervention into medical affairs. Therefore, I am happy to be here and hope that you will adopt Resolution 78-7, extending to medical students a chance to participate in the Indiana State Medical Association.

Reports of Officers

Executive Director

ACTION: Filed.

This report, my third, to the House of Delegates and the members of ISMA happily finds the Association in sound financial condition as reflected in current operating statements. Membership has shown a steady increase and expenses have, for the most part, remained below budget. The financial report to be presented to you by the Treasurer at the ISMA annual meeting continues to reflect a gradual build-up of our liquid reserves. Such reserves form the basis for an adequate emergency reserve for meeting operating expenses in addition to the capability of meeting major challenges to the practice of medicine. You are well aware of the effects of inflation in your practices, and I must remind you that it is having the same insidious impact on the Association's finances. As time goes by, inflation inevitably will absorb more and more of the comfortable year-end reserves that we have recently been accumulating.

In attempting to strengthen its surveillance of federal activities and programs which threaten the fabric of private practice, ISMA submitted comments on numerous federal bills and proposed regulations. A successful coordinated effort was undertaken to prevent Congressional adoption of HEW's National Health Planning Guidelines in their original form.

At the invitation of the AMA, the ISMA sent a special delegation to Washington, D.C. to lobby members of the House Interstate and Foreign Commerce Committee on the proposed amendments to the Health Planning Act (P.L. 93-641), the extension of certificate of need to physicians' offices, and the various cost containment proposals.

In order to facilitate its stepped-up activity focusing on the federal level, the Board of Trustees earlier this year authorized the employment of an additional full-time attorney which also prompted a reorganization of ISMA staff. His principal role is to identify possible areas to challenge in federal programs and regulations that adversely impact the practice of medicine. Additionally, he is to provide advice and counsel to physicians participating in federally financed programs (HSAs, PSROs, etc.). Increased contacts and the development of working relationships have been initiated with Congressional as well as HEW staffers.

This year's session of the legislature, besides being a short session, was a relatively uneventful one. There was no chiropractic challenge to contend with and there were no major surprises from organized consumer groups. We were successful again in averting passage of certificate of need legislation and we are working hard to prevent its extension to physicians' offices being mandated in federal legislation. Particular

vigilance will be required in dealing with legislative proposals from other health professionals regarding scopes of practice. Federal reimbursement is now available to "Rural Health Clinics" for the services of physicians' assistants and nurse practitioners with minimum physician supervision consistent with state law.

Because of vigorous protests by ISMA and IHA to the Department of Public Welfare's rules and regulations implementing a Prior Approval Program for services to Medicaid beneficiaries, the Governor persuaded the Department's Administrator to withdraw the proposed regulations. The ISMA has spearheaded a multidisciplinary committee in rewriting the regulations which have been presented to the Governor's office for review.

Under the very able leadership of your president, ISMA assumed a leadership role in forming the Indiana Task Force on Cost Containment which is Indiana's counterpart of the National Steering Committee dedicated to promoting the "Voluntary Effort" program for containing health costs. The Indiana Task Force which is broadly based, like its national counterpart, includes representation from medicine, hospitals, health insurers, government, industry, labor banking and consumers. The Task Force has met three times thus far and is making excellent progress in stimulating cost consciousness and implementing the objectives of the "Voluntary Effort."

Under a contract negotiated with the Indiana State Board of Health, your Association recently completed a most successful survey of specialized health services available in hospitals throughout the state. The response rate was most gratifying with approximately 80% of the institutions returning completed questionnaires. This was possible because of splendid cooperation from the chiefs of medical staffs and hospital administrators.

This year has witnessed the programming and phasing in of ISMA's own in-house computer system for membership. An IBM Systems 32 has been installed at headquarters and AMA's AM-CAP system has been terminated. The next dues bill sent to ISMA members will be generated and processed by ISMA's computer.

Consistent with House of Delegates' policy established at its 1977 meeting which declared ISMA's opposition to all insurance contracts containing a reimbursement (differential) provision for participating vs. non-participating physicians, ISMA registered a complaint with Indiana's insurance commissioner, citing the Vision Care Program of the United Auto Workers as an example. The insurance commissioner has responded and requested documentation of actual economic injuries suffered by patients and physicians resulting from par vs. non-par contracts. His request has been referred to Medical Eye Services of Indiana

Reports of Officers

(MESI) for further handling.

During 1977 the chairman of the Indiana Medical Education Foundation Committee initiated a meeting with the Executive Committee to discuss the need for reorganization of the Foundation's structure so as to insure more positive administrative control and to avoid any future legal complications. With the assistance of outside legal counsel and the cooperation of the Dean of I.U. School of Medicine, a new resolution amending the resolution that established the Foundation was drafted and presented for the Executive Committee's consideration. Essentially, this resolution (1) changes the name of the Committee from the Indiana Medical Education Foundation Committee to the Indiana Medical Education Fund, (2) establishes a new committee structure, and (3) fixes responsibility and reporting. It was recommended that regular reports of financial condition of the Fund be made to the Executive Committee in addition to an annual report to the House of Delegates. Such a report will be presented at this year's annual meeting.

Medical Protective Company has indicated that effective September 1, 1978, it will no longer charge an additional malpractice insurance premium differential for those physicians who have had suits filed against them. However, overall premium rates will increase due to increases levied by the re-insurance market.

All ISMA members can be justly proud of the manner in which they are represented at AMA meetings by Indiana delegates and alternate delegates to the AMA. Under able leadership, the delegation has achieved great credibility and rapport with the AMA House of Delegates. This acceptance was no doubt largely responsible for the election of two of Indiana's delegates, Peter Petrich, M.D., and Malcolm Scamahorn, M.D., to the Council on Constitution and Bylaws and the Council on Medical Services respectively at the 1978 AMA annual convention. It is obvious to most observers that Indiana's influence in the AMA House of Delegates is far in excess of the number of votes it casts.

Headquarters is constantly seeking ways in which to improve the timeliness of communications with the membership. During the last legislative session we launched a weekly legislative update (newsletter) which we plan to continue. Any ideas or suggestions for improving communications are most welcome.

As far as national health insurance is concerned we can expect the emergence this fall of a Carter Administration initiative, if not a bill. But what sort of proposal this will be remains to be seen. There are strong forces pushing for a broad, maximum approach and strong forces pushing for a minimal bill. Actually there is only one thing certain regarding health insurance legislation—it will begin to heat up as a politi-

cal issue late this year. It is interesting to note, however, that the once-solid support of the academic community for large federal health programs has been shattered by a wave of intellectual pragmatism that has sharply challenged the traditional liberal dogma that the solution always lies with the government. A prime example of this change has been the dwindling support for labor's national health insurance plans to federalize the health care system. Few academicians now stand to defend this broad approach, as once they stood solidly behind such proposals as Medicare and the now-defunct regional medical program.

Even more significant are the results of a recent study commissioned by Hospital Affiliates International, Inc., a subsidiary of INA Corporation, to provide an up-to-date, detailed analysis of how the American public views hospital care. While six out of seven people who had ever been hospitalized indicated they were satisfied with the quality of care they had received, a consensus exists among the public that the need to control costs and provide health care to those who cannot afford it is the number one priority for change. The survey disclosed that by 46% to 38% the public is against government regulation of hospitals. More importantly, the public disapproves of strict regulation in any area of hospital decision-making and they overwhelmingly oppose—by 85%—regulations which would inhibit the prerogatives of physicians.

DONALD F. FOY
Executive Director

Chairman, Board of Trustees

ACTION: Filed.

During the 1977-1978 year of activity the Board of Trustees devoted seven weekends and long hours of deliberation to a broad cross section on matters of importance to the membership.

In this report I will highlight some of the important matters the Board considered and took action upon. Although this report does not begin to cover all the actions of the Board, the minutes of our Board meetings are always open to any member who wishes to review them.

AMA MEETINGS: Board was briefed in detail by AMA delegates and alternate delegates prior to the annual and clinical sessions of the AMA and, in a number of instances, gave direction to the delegation as to how they should vote on specific resolutions and reports which were to come before the AMA House. The Board also directed the delegation to support a number of Indiana candidates for offices on AMA Councils, and this was accomplished successfully.

STUDENT ASSISTANCE: Offered financial assistance to a student representative to attend the Student Business Session of the AMA.

Reports of Officers

NATIONAL GUIDELINES FOR HEALTH PLANNING. Condemned the National Guidelines for Health Planning in that they potentially could cause the closing of small rural or community hospitals and, in addition, directed staff and trustees to visit each Indiana Congressman's office to explain ISMA's position and philosophy.

USE OF DRUGS BY OPTOMETRISTS: Expressed ISMA's concern and disapproval to the Medical Licensing Board that the use of drugs by optometrists is the practice of medicine and that, in instances wherein the Licensing Board knows that such is the case, action be taken against those involved.

DIFFERENTIAL REIMBURSEMENT: Took action to oppose all types of contracts that contain reference to differential reimbursement for participating vs. non-participating physicians.

NOMINATIONS FOR BLUE SHIELD BOARD: Selected nominees for members at large of the Blue Shield Board through a process of interviews and discussions.

COMMERCIAL EXHIBITS: Authorized the staff to solicit commercial exhibits for the annual convention.

SPORTS AND MEDICINE: Endorsed the Indiana Sports Medicine program and allocated \$4,000 seed money to initiate the program in Indiana.

DATA PROCESSING: Endorsed the Data Processing Steering Committee's approval in principle of ISMA's involvement in meeting the data processing requirements of the various Indiana PSROs. Requested the ISMA legal counsel to research the status and potential use of I-MEDIC as a mechanism for accommodating future ISMA computer applications.

ISMA POLICIES: Directed the staff to compile by the annual meeting in October a reference guide index of ISMA policies established over the past five years. Staff is in process of completing the task.

DISTRICT CONSTITUTIONS: Directed the staff to obtain constitutions and bylaws of each district medical society and develop model bylaws which the districts can adopt and use as guidelines.

ISMA AUXILIARY: Heard periodic reports from the president of the Auxiliary on its current activities.

MEMBER INSURANCE: Approved an increase in the major medical maximum from \$250,000 to \$1,000,000 lifetime with no increase in premium for the Blue Cross-Blue Shield Plan A (first dollar coverage, full service policy including major medical). Also approved a \$250 deductible under Blue Cross-Blue Shield Plan B, major medical only.

EXCESS MAJOR MEDICAL INSURANCE: Approved continuing this program and approved resolicitation of ISMA membership for enrollment in the Group Term Life Insurance Plan. Also requested that

the insurance company obtain appraisal for an open enrollment for the substandard disability insurance program.

OPPOSITION TO NHI: Polled the ISMA membership on attitudes toward National Health Insurance. Majority of physicians voted against withdrawal of an AMA-sponsored bill in Congress.

ANNUAL WASHINGTON VISITATION: Planned and carried out with the Executive Committee the annual Washington visit with Indiana Congressmen.

DATA COLLECTION: Followed closely ISMA's first involvement with data collection through a grant from the Indiana State Board of Health. Data on specialized health services were collected from Indiana hospitals to assist the ISBH and its Technical Advisory Committees in developing criteria and standards. The rate of response from Indiana hospitals was most gratifying.

VIDEO TAPE RECORDER: Authorized the purchase of a video tape recorder to capture special TV commentaries on health issues and subsequent recirculation to county societies.

VISION CARE PROGRAM: Authorized a letter of formal complaint to the Indiana Insurance Commissioner objecting to Blue Shield's implementation of the auto workers contract that contained a vision care program benefit, which the Board of Trustees felt was in violation of Indiana insurance law because of the par vs. non-par clause in the contract.

SECOND SURGICAL OPINIONS: Opposed the concept of mandatory second surgical opinion and advised Blue Cross and Blue Shield of this stand.

STATE PSRO COUNCIL: Directed the ISMA through I-MEDIC or through a group of interested persons associated with ISMA to attempt to maximize its influence in the formation of a statewide PSRO Council.

NATIONAL HEALTH SERVICE CORP: Worked in conjunction with county medical societies in placement of physicians through the National Health Service Corp. (NHSC).

LEGISLATION, NEGOTIATIONS, ETC.: Through reports from other offices and periodic guest presentations, the Board was kept abreast of arbitration and negotiations, planning activities, state and national legislation, progress of the special Cost Containment Committee and numerous other activities involving commissions and committees of the Association.

FEDERAL INVESTIGATIONS: Registered an objection with the Indiana State Board of Health for federal scrutiny for medical reasons of Indiana communities without notification of county medical societies.

SEPARATION FROM BLUE SHIELD: Considered the proposal of separation from Indiana Blue Shield, and subsequently adopted a resolution by the

Reports of Officers

Board that commended the history and beneficial actions of Medical Mutual Insurance Company and its Board in providing the best health care benefits for its policy holders and urged continuation of these achievements.

MARTIN J. O'NEILL, M.D.
Chairman, Board of Trustees

Executive Committee

ACTION: Filed.

Prior to the July 15, 1978 deadline for reports to the House of Delegates, the Executive Committee had met seven times and anticipated several additional meetings prior to the convention. Consequently this report will contain highlights of some of the committee's considerations to date as follows:

1. Routinely reviewed the financial condition of the Association and authorized investment of funds.
2. Completed review of the employees pension plan and authorized its continuation in conformity with government regulations.
3. Approved and/or disapproved numerous requests for the ISMA mailing list for a broad variety of programs and purposes.
4. Made liaison appointments to a number of health related organizations to insure official medical organization representation. Gerald Johnston, M.D., for example, was named to the Project Advisory Committee of the Indiana Department of Health.
5. Rejected the Louisiana State Medical Society's request for financial support of its "Doctors of Concern" program, designed to provide physicians with an analysis of the proposed AMA NHI legislation.
6. Recommended to the Board of Trustees that ISMA continue to oppose all types of contracts that contain references to differential reimbursement for participating vs. nonparticipating physicians.
7. Continued surveillance of legal fees and activities relating to ISMA outside legal consultants.
8. Recommended to the Board that the Impaired Physician Committee remain a committee at this time and that the president be encouraged to appoint, on a geographical basis, members to serve on the committee in an advisory capacity.
9. Approved a resolution amending the original resolution that established the Indiana Medical Foundation, which changed the structure of the Foundation to insure more positive administrative control and to avoid any future legal complications. A complete report regarding the status of the Foundation (Fund) will be presented to the House of Delegates at the October 1978 meeting.
10. Reviewed draft comments on Criteria and

Standards for Acute Inpatient Care Facilities and services in Indiana, and authorized their submission to the Indiana State Health Planning and Development Agency.

11. Authorized the temporary utilization of office space in the headquarters office by the Indiana Chapter of the American College of Emergency Physicians.

12. Requested the attorney general of Indiana to file an amicus curiae brief in favor of the North Carolina and Nebraska suits, which challenged the constitutionality of PL 93-641, National Health Planning and Resources Development Act of 1974.

13. Approved a staff reorganization.

14. Authorized staff to investigate proceedings for terminating the Student Loan Program.

15. Reviewed a staff-developed report on the origin, development and current relationship with Indiana Blue Shield (Mutual Medical Insurance, Inc.) as a result of action by the 1977 House of Delegates, and recommended to the ISMA Board of Trustees that ISMA continue to maintain its present association with the Blue Shield Board and that the current ineffectiveness of ISMA's association with the Blue Shield Board be improved.

16. Investigated properties for sale and lease that would offer expanded office space for future ISMA activities.

17. Recommended that ISMA study the independent CME accreditation program being conducted by the California Medical Association with a view toward establishing a similar program in Indiana.

18. Reviewed requests for medical defense from members and made appropriate disposition of such reports.

JOHN W. BEELER, M.D.
Chairman

JOE DUKES, M.D.
ARVINE G. POPPLEWELL, M.D.
JOSEPH F. FERRARA, M.D.
JAMES A. HARSHMAN, M.D.
ELI GOODMAN, M.D.
MARTIN J. O'NEILL, M.D.
RICHARD INGRAM, M.D.

Reports of Officers

Treasurer

ACTION: Referred for final audit.

The detailed report of the financial condition of the Association on September 30, 1978 will be made available for the Reference Committee prior to the annual meeting, along with a report of the anticipated budget for 1978-79. Being published at this time is the statement as of June 30, 1978.

If one extends the estimated remainder of expendi-

ture for the rest of this year, the total expenditure anticipated at the end of the year as of September 30, 1978 is expected to provide an income again over the expense. At this point it is anticipated at being approximately \$105,000 for all funds. For the general fund itself, we are expecting an anticipated increase of approximately \$80,000.

Over the past few years we have made an attempt to increase the balance in the general fund and to decrease the number of special funds that we have to

INDIANA STATE MEDICAL ASSOCIATION

Statement of Financial Condition

ASSETS			LIABILITIES AND FUND BALANCES		
	6/30/78	9/30/77		6/30/78	9/30/77
GENERAL FUND:			GENERAL FUND:		
Cash on deposit	\$ 33,176	\$ 49,583	Accounts payable	\$ 1,062	\$ 25,457
Investments at cost:			Accrued taxes	—	134
U.S. Treasury Bonds-long term	60,122	35,070	Dues payable to AMERF	21,855	21,788
U.S. Treasury Bills, Certificates of Deposit-short term	1,084,834	769,156	Dues payable Counties, Districts, AMA	11,948	—
Accounts receivable	56,981	44,718	Unearned portion of current year dues	381,016	190,640
Prepaid expense and miscellaneous assets	13,981	15,661	Deferred annual meeting income	6,625	3,050
Office furniture and equipment-net of accumulated depreciation	20,434	21,929	Deferred Journal income	3,500	—
	<u>1,269,528</u>	<u>936,117</u>	Fund balance	843,522	695,048
				<u>1,269,528</u>	<u>936,117</u>
BUILDING FUND:			BUILDING FUND:		
Cash on deposit	2,979	1,758	Accrued taxes on rental properties	738	952
Cash in savings account	—	8,576	Damage deposits and accounts payable	690	2,052
U.S. Treasury bills	303,059	278,562	Loans from members (Non-interest bearing)	6,150	7,750
Prepaid and deferred expenses	896	439	Fund balance	655,782	639,005
Headquarters property:					
Land	69,188	69,188			
Office building and improvements-net of accumulated depreciation	214,794	216,625			
Rental properties—net of accumulated depreciation	72,444	74,611			
	<u>663,360</u>	<u>649,759</u>		<u>663,360</u>	<u>649,759</u>
STUDENT LOAN FUND:			STUDENT LOAN FUND:		
Cash in savings account	—	19,190	Fund balance—principal balance		
U.S. Treasury Bills	19,190	—	appropriated from General Fund	40,000	40,000
Certificate of deposit	20,810	20,810		<u>40,000</u>	<u>40,000</u>
	<u>40,000</u>	<u>40,000</u>			
MEDICAL DEFENSE FUND: (Closed to the General Fund)			MEDICAL DEFENSE FUND:		
Cash in savings account	—	44,414	Fund balance		
U.S. Treasury Bonds	—	25,288	(Closed to the General Fund)	—	69,702
	<u>—</u>	<u>69,702</u>		<u>—</u>	<u>69,702</u>
MEDICAL EDUCATION FUND:			MEDICAL EDUCATION FUND:		
Investments	354,179	354,179	Committed to Indiana University	354,179	354,179
	<u>354,179</u>	<u>354,179</u>		<u>354,179</u>	<u>354,179</u>
	<u>\$2,327,067</u>	<u>\$2,049,757</u>		<u>\$2,327,067</u>	<u>\$2,049,757</u>

Reports of Officers

keep. As a result, only the student loan fund, building fund and general fund now exist. The remainder of the funds belonging to the Association have been amalgomated into the general fund. For an association of this size there has been a general feeling that we should try to eventually arrive at a general fund balance of \$1,000,000, which would be slightly over one year's operating fund. This would allow in any one year the Board of Trustees to meet emergencies that might come along in the way of legislative activities, or our new public relations program that is felt to be necessary on a one-time basis. It would appear that if we are confronted with expenses that are going to provide an ongoing obligation requiring dues increases, that these then need to be brought forth at our annual meeting.

In 1975 the general fund balance was \$292,110; the medical defense fund at that time was \$56,000 and that, of course, has now been amalgomated.

In 1976 the general fund balance, together with the medical defense fund, was \$575,690.

In 1977 we finished with a fund balance of the now general fund of \$764,750.

Currently, the anticipated budget for 1978-79 has been prepared so that no increase in dues is necessary unless recommendations from the House of Delegates on resolutions with budgetary significance are passed.

It has been a distinct pleasure serving our association first as assistant treasurer and now as treasurer. I want to thank other members of the Board of Trustees and the Executive Committee and members of the staff of our Association for their assistance during the year.

ARVINE G. POPPLEWELL, M.D.
Treasurer

Indiana Delegation to the American Medical Association

ACTION: Filed, with commendation to the Indiana Delegation to the AMA.

The Annual Convention of the American Medical Association was held in St. Louis June 18, 1978 through June 22, 1978 and a full contingent of Indiana's delegates and alternate delegates was in attendance.

In addition to closely following the proceedings of the House of Delegates and participating in debates on the floor, the Indiana contingent accomplished the election of two of its delegates to important councils of the AMA. Peter R. Petrich, M.D. was elected to the Council on Constitution and Bylaws and Malcolm O. Scamahorn to the Council on Medical Service, both to three-year terms.

Highlights of the House of Delegates included the following:

Report of National Commission on Cost of Medical Care: The delegates accepted major portions of the

Report of the National Commission on the Cost of Medical Care, and agreed to give other recommendations further study.

They rejected one cost commission recommendation by reaffirming AMA policy. The recommendation called for physicians and others to reach agreement on the reasonableness of levels of reimbursements. Delegates reaffirmed the policy that fee information should be available to the patient, and that ability to pay should be considered. They also reaffirmed the opposition to the use of uniform fee schedules.

This was the only commission recommendation neither approved nor referred. The comprehensive document, which attempts to elucidate factors responsible for escalating health care costs as well as recommend methods to contain them, caused some confusion as delegates grappled with language they had not written and could not change.

The commission was sponsored by the AMA, but its report was independently prepared by the 27 commission members, including representatives from health care providers, government agencies, business and labor.

New President's Comments: Tom E. Nesbitt, M.D., new president of the American Medical Association, urged all physicians to cut the rate of their professional fee increases over the next two years.

Dr. Nesbitt called for voluntary restraints during his inaugural address. He stated that such restraints would help combat the Administration's attempt to impose a national health service on the public. "We physicians, after all, are not exempt from the hard realities of today's economy . . . from the general inflationary spiral. And these added costs necessitate periodic increases in our professional fees. What each of us can do, however, is place realistic restraints on the rate of these periodic increases while maintaining the quality of patient care."

Dr. Nesbitt suggested that physicians should cut the rate of their fee increases by 1% each year for the next two years. He noted that these restraints would reinforce an "existing downward trend in the rate of increase of physicians' fees" and bring the fee escalation rate close to the "all-items" rate on the Consumer Price Index, or "perhaps under it, if recent all-items price increases continue."

Dr. Gardner, President-Elect: The American Medical Association's new president-elect, Hoyt D. Gardner, M.D., a Louisville, Ky., general surgeon, will use the presidency as a platform "to go back to the grassroots and promote professional unity."

In his first press conference after election, Dr. Gardner said, "The presidency is a great symbol the Association can use to reach out and touch its members and be touched in return."

Turning to the chief issue at this year's annual con-

Reports of Officers

American Medical Association Delegation

vention, Dr. Gardner said he thought "America's physicians will support the recommendation of the National Commission on the Cost of Medical Care. . . . Physicians are objective and they tend to be very responsive once they are aware of a problem."

Principles of Medical Ethics: The House of Delegates asked the Judicial Council to reconsider its proposed revision of the Principles of Medical Ethics. What had seemed likely to be one of the most contentious issues at the AMA annual meeting was put aside for further consideration. An ad hoc committee of the house was created to study the matter, and was asked to report back to the house at the next meeting.

Health Planning: Medical societies must become politically active and involved in all levels of the planning structure, the Delegates stated. AMA also opposed proposed regulations for the composition and selection of HSA governing bodies and opposed proposed rules on appropriateness review by HSAs and State Health Planning and Development Agencies. AMA's Council on Legislation is preparing comments on these regulations.

A report adopted by the house summarized activities of the Council on Medical Service's ad hoc committee on health planning and updated recent developments in the field.

The report recommended the following principles for effective medical society participation in planning activities:

- Closely monitor the Health Systems Plan and the Annual Implementation Plan development activities and provide appropriate comment to the HSA during each stage of development.

- Establish state and local physician bodies to monitor HSA activities and to respond to HSA actions on behalf of the health service area's medical community.

- Maintain dialogue with other medical societies in regard to their efforts, strategies, and ideas in response to implementation of PL 93-641.

- Draw upon individuals with expertise for interpretations of the planning law's provisions.

- Provide adequate staff to monitor and analyze HSA activities and to ensure distribution of all appropriate planning materials to concerned physicians.

- Work to assure the appropriate exclusion of physicians' offices from review.

- Monitor the use of data and assist PSROs and HSAs in interpreting data.

- Consider entering into agreements with HSAs to assure ongoing medical input and coordination with local planning activities.

- Establish programs to keep consumers better informed.

- Identify and disseminate information on any adverse effects to patient care as a result of the application of the planning law or its regulations.

National Health Insurance: National health insurance, the issue that has dominated recent sessions of the AMA House, was put on hold at the convention. It will return, however, at this winter's Interim Meeting. Debate was relatively brief and subdued both before the reference committee and house, as delegates directed the Board of Trustees to determine if a new or substitute bill for HR 1818, the Comprehensive Health Insurance Act of 1977, "is necessary or not." If it is, the house directed, and "if an AMA-sponsored NHI bill is to be submitted at the Interim Meeting, it should be circulated to the members of the house as early as possible so it may be studied in detail before that session."

The house, in effect, asserted its prerogative to approve the precise language of any NHI bill that might be submitted to the new Congress by AMA, a development that heretofore has been for all practical purposes, determined by the Council on Legislation.

PSRO Action: AMA vigorously opposed any attempt to mandate the use by PSROs of national criteria without allowing for local amendment, modification, or adaptation.

Criteria should be used for screening purposes only, subject to peer review, a resolution adopted by the House of Delegates said. The resolution noted that the National PSRO Council has created guidelines relative to the 11 most commonly performed surgical procedures with plans calling for expansion to include criteria for more than 100 additional surgical procedures by Jan. 1, 1979. In making its recommendation, the reference committee noted that the guidelines will be offered only as sample screening criteria, for use or adaptation by individual PSROs at their discretion.

Bypassing Medical Staff Bylaws: The AMA opposed any unilateral action of hospital boards of trustees that alters or bypasses previously adopted and approved medical staff bylaws, rules, and regulations.

The resolution approved by the House of Delegates also supported the right of all medical staffs to conduct the practice of medicine in all facilities according to the rules and regulations governing the staffs as set forth in the bylaws, rules and regulations drawn up and adopted by the medical staffs and approved by the governing body.

In-Office Insurance Coverage: The AMA will urge the Blue Cross-Blue Shield Assn. and the Health Insurance Association of America to refrain from providing policies that penalize patients for selecting their physicians' offices for performance of medical and surgical procedures.

Reports of Officers

American Medical Association Delegation

The resolution approved by the AMA House of Delegates is aimed at insurance companies that provide policies that pay for medical or minor surgical services when rendered in the hospital emergency rooms but not in physicians' offices.

In related actions, the house opposed the current Presidential recommendation to increase the exclusion from allowable deductions for medical expenses from 3% to 10% for Internal Revenue Service purposes.

CME Accreditation: The House rejected a proposal to recognize state medical societies as the only authorized agencies for accrediting continuing medical education programs.

The action means the state societies will continue to have the right to conduct surveys of CME programs and make recommendations for accreditation, but the Liaison Committee on Continuing Medical Education (LCCME) will have the responsibility for making the definitive decision.

Student Loans: Student loans are getting scarcer at a time when the cost of medical education is soaring.

Some lending institutions are cutting back on loans to medical students as a result of an increased rate. To meet the soaring demand for assistance, AMA officials announced during the St. Louis convention plans to limit to 50 the number of students at any medical school who may obtain guaranteed loans from the AMA Education and Research Foundation. A California delegation resolution calling on the AMA to take a position that it is unethical for any physician not to repay his or her educational loan was referred to the Board of Trustees for study and for developing recommendations to discourage defaults.

Healthier Lifestyles: The House took positive actions on several resolutions that suggested that the public has been lax about maintaining its personal health and so needs education on healthier lifestyles.

For example, the delegates endorsed the use of crash helmets as "the single most effective countermeasure to severe or fatal head injury in motorcycle-related crashes."

Delegates from New York, Indiana, Maine and the American Academy of Pediatrics all rose to support the report of the Council on Scientific Affairs, which recommends that any person riding a motorcycle wear a properly fitted full-facial helmet and that this statement be distributed to all appropriate safety and motorcycle organizations.

Jail Project: The expansion of the American Medical Association's jail health program was announced during the annual meeting. Nine states and the District of Columbia will be included in the program, funded by a Law Enforcement Assistance Administration grant and designed to upgrade jail health care by providing

states with minimum health and medical standards for the jail setting. Illinois, Massachusetts, Nevada, Ohio, North Carolina, Pennsylvania, South Carolina, Texas, Washington, D.C. and one state as yet unnamed will join the six pilot states already using the standards developed by the AMA's Jail Health Project two years ago. The six pilot states are Georgia, Indiana, Maryland, Michigan, Washington and Wisconsin.

AMA DELEGATION

Interim Meeting: Dec. 4-7, 1977

Chicago was the scene for the Interim meeting of the American Medical Association's House of Delegates, Dec. 4-7, 1977, at the Palmer House, and Indiana's delegation of officers, delegates and alternate delegates were in full attendance.

The Indiana delegation introduced five resolutions dealing with seconding nominations in AMA elections, AMA dues credit, council representation on reference committees, leadership in the American Blood Commission, and proficiency in advanced cardiac life support.

Seconding of Nominations: The resolution on seconding of nominations was amended and adopted by the AMA House. The Indiana delegation had asked that the seconding of nominations for all elected positions be eliminated. The reference committee recommended instead that the entire nomination and election procedure including seconding of nominations be examined by the Board of Trustees and their recommendations reported back to the 1978 Interim meeting of the House.

AMA Dues Credit: The AMA dues credit resolution stated that AMA members who have paid the special assessment be credited with \$60 toward their AMA dues the year following that time the American Medical Association reserve fund reaches an adequate level.

The reference committee recommended rejection of this resolution since no specific time frame was proposed by the resolution and stated that they would prefer that the AMA Board not be obligated at this time to a specific mechanism which would reduce AMA reserves. The committee pointed out that when and if such actions become feasible, the mechanism proposed by the Indiana resolution could be considered. As of Oct. 31, 1977, 151,819 members had paid a total of \$9,109,140.

Council Representation on Reference Committees: The AMA House rejected Indiana's resolution concerned with council representation on reference committees. The reference committee reported to the House that it believes the present system of selecting reference committees is fair and equitable. Adoption of the Indiana resolution, they said, would prevent 40 mem-

Reports of Officers

American Medical Association Delegation

bers of the House from serving on a reference committee.

The Indiana delegation had asked that a council member of the AMA not sit on a reference committee which was considering items presented by a council of which he is a member.

Leadership in the American Blood Commission: Leadership in the American Blood Commission resolution was adopted by the AMA House. The resolve stated that the AMA continue to play an affirmative leadership role in the activities of the American Blood Commission and the formulation and implementation of the National Blood Program.

Proficiency in Advanced Cardiac Life Support: On the matter of proficiency in advanced cardiac life support, the reference committee recommended amendment and adoption. The amendment did not change the intent of the resolution which resolved that the AMA recommend that all licensed physicians become and remain proficient in basic Cardio-Pulmonary Resuscitation (CPR) and also resolved that all licensed physicians become proficient in advanced Cardiac Life Support commensurate with their responsibilities in critical care areas.

Comprehensive Health Insurance: The vote was 4-1 (178-46) this time as American Medical Association delegates renewed their support for AMA-sponsored legislation on comprehensive health insurance. The arguments go back a decade and there was nothing new in the debate at the 1977 interim meeting.

Once again, Louisiana and its alternate delegate, F. Michael Smith, M.D., led the opposition against an AMA bill. Dr. Smith asserted that the proposed AMA bill would by 1980 cost \$196 billion, a figure "one-and-three-quarter times the total corporate profits of America."

Russell Roth, M.D., a past president of the AMA and the architect a decade ago of AMA's legislation for comprehensive health insurance (it was called "Medicredit" then), said, "I am pleased at these Louisiana figures about how much our bill will cost. The AMA should not be offering bargain-basement medical care."

Specialty Society Representation: After nearly three hours of heated debate, the AMA's House of Delegates totally revamped the section council system and set specific criteria for giving specialty societies direct representation in the AMA.

The actions eliminate delegates to the house from the 28 section councils and instead will enable any specialty society that meets the criteria to request the seating of its own delegate. The move is a major policy change that can greatly expand specialty society representation in the AMA, and in doing so can pro-

vide a stronger, more united voice for American medicine, proponents said.

Blues' Policies: Delegates to the interim meeting resoundingly opposed the "participate or perish" practices of some Blue Shield/Blue Cross plans.

A report that was quickly accepted by delegates pointed to two new health insurance coverages, the so-called vision and hearing program—involving differential payment for the services of participating and non-participating physicians—as being responsible for recent weakening in the relationships between physicians and the plans. Delegates accepted the Board of Trustees' proposal to work with the Council on Medical Service and other AMA councils and committees in making an in-depth study of the problem, and reporting its findings at the 1978 Annual Meeting.

They also adopted a resolution urging the AMA to oppose third-party differentiation between covered services provided by participating and non-participating physicians as discriminatory against the physician who does not have a separate contractual relationship with the carrier, and as inhibiting the patient's free choice of physician.

The resolution also urged that the AMA position be communicated to all health insurance carriers.

Professional Standards Review Organizations: Professional Standards Review Organizations remained a focal point of discussion, with some half-dozen PSRO-related items acted upon by delegates to the AMA's interim meeting.

At the heart of physician concern was the essential purpose of the organizations. "Our concern should be with the HEW thrust to make PSROs something other than what they were originally intended to be," a delegate stated. "If they are to become agencies promoting second opinions for surgery, or organizations designed to root out fraud and abuse, their original purpose will be changed. PSROs were designed to assure quality of care. Necessity of surgery can be a legitimate concern of PSROs, but if they are to be molded into police agencies for federal programs they will not be following their mandate. Our job is to watch them carefully."

Responding to that position, delegates urged the AMA to conduct ongoing evaluation of the PSRO program to ensure that its primary focus remains on quality and appropriateness of care, rather than on cost containment or surveillance.

Delegates also urged that the AMA adopt the policy that physicians be reimbursed for all mandated PSRO activity, and that the level of reimbursement be negotiated by each PSRO, with no arbitrary dollar limit imposed by the federal government.

Legislation: AMA delegates approved a series of legislative amendments designed to stem the growing

Reports of Officers

American Medical Association Delegation

federal intrusion into medicine. The legislation, developed by the AMA Council on Legislation, and endorsed by the Board of Trustees, was in response to resolutions approved at the 1977 annual convention.

The proposed legislation would:

- Change the Health Professions Educational Assistance Act so that medical schools will not be required as a condition of receiving capitation grants to accept as third-year transfers U.S. citizens enrolled in foreign medical schools; and so that a proposed HEW health professions data system will not single out physicians and dentists as the first group about whom data will be collected.

- Assure that the Food and Drug Act continue to make available "safe and effective" drugs, while at the same time minimizing the time required to put drugs on the American market. Of special concern is Patient Informational Leaflets, which, delegates directed, should not be mandatory for all drugs.

- Assure adequate physician representation on health planning agencies and prevent the imposition of national guidelines for health planning. In a related action, the house directed the AMA to be prepared to join a state medical society's suit, should one legally challenge any state certificate-of-need law that includes physicians' offices.

- Place all government institutions, except for the military, under the same health planning, Professional Standards Review Organization, and other federally mandated health care requirements that are currently imposed—by federal law—upon private institutions.

- Assure the confidentiality of PSRO data.

- Prevent Medicare payments for physician extenders not under the direct supervision of a physician.

Guidelines for Medical Directors: Twenty-two suggested guidelines for physicians attending patients in skilled nursing and long-term care facilities were adopted by the AMA House.

The guidelines, prepared by the AMA Council on Medical Service, are intended to clarify the role of attending physicians in long-term care facilities, help them in maintaining a high level of care in these institutions, and assist them in working with the medical director to achieve that end.

The new guidelines supplement the 1973 "Guidelines for a Medical Director in a Long-Term Care Facility" and replace a 1959 report. The council noted that the guidelines should be taken as general suggestions only, and will need to be adapted to local conditions.

Marihuana: While echoing its long-standing position that there is "little conclusive evidence of long-term adverse consequences of marihuana use in the United States," and discouraging marihuana use, the House of

Delegates also said that "a criminal record is a handicap . . . for life" that can cause stress and anxiety, a "genuine medical concern."

The house urged that the penalties for possession of small amounts of marihuana be "modified," though criminal sanctions should still be imposed for drug trafficking.

This statement came at the heels of the recent call by both the AMA and the American Bar Association to decriminalize the laws concerning possession of marihuana nationwide. The house voted to support the position that "for healthy users intermittent ingestion of even relatively potent marihuana rarely constitutes a health hazard," but warned that "regular ingestion or multiple drug use might."

In advocating a "more realistic and humane legal approach," the house also said that modified laws should be "enforced vigorously and equitably so as to discourage use wherever possible and to reflect the continuing conviction that marihuana is not a harmless drug."

Patient Package Inserts: It is the prerogative of the physician to determine whether a patient receives an information leaflet with his prescription drugs, House of Delegates decided. This stand on patient package inserts (PPI) is a modification of the hard line adopted by the house at the 1977 annual convention, when it said that the AMA "opposed mandatory PPIs for all drugs."

Not all prescriptions require PPIs, the house said at its interim meeting, but when included, the information should "enumerate only selected, significant, documented side effects and adverse reactions" and avoid mentioning any bizarre contraindications.

It was also recommended that PPIs should not be developed unilaterally by the federal government, "but should represent a cooperative effort by the major organizations of medicine and pharmacy," the house said.

AETNA Health Advertising: The health advertising campaign of Aetna Life and Casualty Insurance Co. came under sharp attack at the Interim Meeting. Physicians complained of the abrasive and simplistic nature of the advertisements, and adopted a report expressing the deep concern as expressed to Aetna by the AMA. The report pointed out that the AMA has inaugurated a substantial advertising program designed to convey the positive accomplishments in medicine and health care.

Other Actions: In other actions the AMA House:

- Adopted a Board of Trustees report describing the joint AMA, AHA, FAH plan to develop a voluntary hospital and medical care cost containment program and urging state medical societies to establish

Reports of Officers

American Medical Association Delegation

joint state level committees with state hospital associations to implement such a program.

► Supported the concept that PSROs or other existing utilization committees make their own determinations as to what constitutes medical necessity for continued hospitalization.

► Adopted as AMA policy the JCAH standard that the hospital medical staff has the right to be represented by physicians elected by that staff at all meetings of the governing body.

► Endorsed the concept that physicians who perform services as the agent of a hospital corporation be properly covered by the hospital's liability insurance and asked AMA to seek immediate modification in hospital accreditation standards that unnecessarily expose physicians to personal medical liability in performing such services.

► Endorsed the development and mandatory installation of effective crash protection systems for motor vehicle occupants and advocated further study of the airbag as a mandatory component of new cars.

ELI GOODMAN, M.D.

President, and Chairman, AMA Delegation

JAMES HARSHMAN, M.D.

PATRICK J. V. CORCORAN, M.D.

PETER R. PETRICH, M.D.

MALCOLM O. SCAMAHORN, M.D.

ROSS L. EGGER, M.D.

DELEGATES

THOMAS C. TYRRELL, M.D.

MARVIN E. PRIDDY, M.D.

GEORGE T. LUKEMEYER, M.D.

GILBERT M. WILHELMUS, M.D.

EVERETT E. BICKERS, M.D.

ALTERNATE DELEGATES

Editor: The Journal

ACTION: Filed.

Financial accounts for THE JOURNAL at the end of the third quarter of the fiscal year indicate that, while the individual items of the budget have varied from predictions, the balance is close to even. Example: Journal income other than dues is up by \$8,000—printing expense is up by the same amount. Also: Number of pages printed is up by 19.3% and the number of copies printed is up by 4.8%. To offset the increased production has required only a 13.7% increase in the amount subsidized by members' dues. Business transacted in the fourth quarter may alter these proportions, but the difference should not be significant.

In addition to an ample supply of clinical articles

submitted by ISMA members from all regions of the state, THE JOURNAL has continued several series of clinical and historical writings and has initiated a new collection of articles written especially for purposes of continuing medical education.

The series of essays on hypertension, written by the various staff members of the Specialized Center of Research in Hypertension at Indiana University School of Medicine, has continued. Each of these presentations deals with a specific consideration in the study of the complex condition of hypertension and is written in as concise a fashion as possible. This series will continue in the coming year and may possibly extend into future years.

At least a part of the credits for continuing medical education may be obtained without closing the office and without large expenditure for tuition and hotel lodging. Indiana University produces clinical articles especially for CME purposes and underwrites the publishing cost. This series has developed into a most popular feature. These essays are accompanied by a multiple-choice quiz the completion of which, if satisfactorily performed, entitles the reader to one hour of CME credit. During the year the number of examinations returned for registration of credit has increased steadily. This feature will be continued in 1979.

Seminars from Riley Children's Hospital have been produced in adequate numbers to outline the diagnosis and treatment for conditions of critical nature in newborns and infants. In addition, information on the routine diagnosis of PKU and hypothyroidism in the newborn has been published in a timely manner.

Medical history in Indiana has been covered by the periodic reports of Dr. Charles A. Bonsett and by a unique letter of historical significance from the pen of Dr. W. N. Wishard, Sr.

Special coverage has been provided for the diagnosis of scoliosis in school children. Legionnaire's Disease has been expounded.

A new human interest series features interesting biographical facts relating to various renowned members of ISMA.

The editorial policy of limiting scientific articles to the space of two journal pages whenever possible has resulted in more concise writing and as a result has increased readability and interest. We go into 1979 with an adequate supply of clinical material and with hopes of shortening the waiting time to publication.

FRANK B. RAMSEY, M.D.
Editor

Reports of Commissions

Commission on Legislation

ACTION: Filed.

The Commission on Legislation has two meetings, which were well attended; at one commission meeting there were 26 members present. We were joined by the officers and the Legislative Committee members of the Indiana Academy of Family Practice. The Medical Licensing Board also met with us on certain occasions. We were ably assisted this year by Richard King, legislative analyst and attorney for the Indiana State Medical Association, and Mark Miles, IMPAC representative. The lobbyists on the floor of the Legislature, again, were Fred Garver and Dick Guthrie who have been our legislative lobbyists for the past three years.

The Indiana State Medical Association House of Delegates mandated actions regarding seven areas of legislation in 1977. All of these have been fulfilled by active support or opposition as directed by the House. We were not defeated in our action on any of these six mandated subjects. The House also requested actions on two areas. These were referred to the Board and are mutually being worked out with the Pharmaceutical Association.

The Legislative subjects that required more time of staff, lobbyists, officers of the Association and the Commission were the bills on Certificate of Need, and Generic Substitution of Prescriptions; both were defeated. However, there was a study commission appointed on the subject of Generic Substitution and there have been three meetings this summer by the Joint Study Commission. Your chairman testified on two occasions before that commission and submitted written testimony on another occasion. It is hopeful that this commission will recommend that there be no need in the present prescription law for consumer protection.

An item introduced that was passed and affects all physicians doing pediatrics and/or obstetrics was the bill requiring compulsory hypothyroidism tests on all newborn babies.

At one of our meetings Dr. Kwitny, a member of the Medical Licensing Board and its Executive Director, spoke to us very candidly about the Board's problems on current and pertinent matters. He specifically discussed the matter of our courts giving restraining order to the Board regarding its activity. These matters will affect upcoming legislation, perhaps in the 78-79 Legislature.

During this year the Legislative Commission has monitored federal legislation, especially that regarding National Health Insurance. President Carter had promised that he would have a proposal for National Health Insurance, but it was not introduced until late July, as some 13 guidelines. There is to be no action in

the national Congress on this subject this year. Doctor Goodman, Mr. Foy and Doctor Scamahorn, the Commission chairman, visited Capitol Hill at the request of AMA and talked to Representative Sharp of Indiana regarding the cost containment bill proposed by the Carter Administration which undermines and essentially does away with the voluntary effort of the medical profession and the hospitals. We are happy to report that Representative Sharp voted against the Carter proposal and gave a very commendable speech on the floor of the House against this proposal.

On the national Congressional level, IMPAC, directed by Mr. Mark Miles, has planned to have a seminar on national health issues, making contact with key doctors and the Commission relative to the congressional problems.

Your Commission wishes to advise the House of Delegates that it believes the problem areas of the next state legislature will be the Certificate of Need, Generic Substitution, an increase in the scope of chiropractic practice and an increase of practice of the chiropractic profession.

The chairman wishes to thank the members of the Legislation Commission and the staff for their loyal and effective support during this past year.

MALCOLM O. SCAMAHORN, M.D.
Chairman

L. RAY STEWART, M.D.
PAUL J. WENZLER, M.D.
PETER H. LIVINGSTON, M.D.
WILLIAM F. BLAISDELL, M.D.
WILLIAM STRECKER, M.D.
KENNETH WOODMAN, M.D.
MARTIN FUNDENBERGER, M.D.
RICHARD REEDY, M.D.
JOHN KNOTE, M.D.
LEONARD W. NEAL, M.D.
THOMAS R. SCHERSCHEL, M.D.
JERRY L. STUCKY, M.D.
ROBERT M. SWEENEY, M.D.
JOHN G. PANTZER, M.D.
PHILIP N. ESKEW, JR., M.D.
JOSEPH BLACK, M.D.
ERNEST R. BEAVER, M.D.
MRS. ROBERT SCHLEINKOFER, Auxiliary
WILLIAM POND, Student Liaison

Reports of Commissions

Commission on Medical Services

ACTION: Filed.

The Commission on Medical Services (CMS) has progressed in 1978 to the point where some of the benefits hoped for from the merger of many preexisting commissions are being reaped. CMS members are drawn from the classic ISMA District selection plus two at-large members which has yielded a rich mixture of rural, middle and heavily populated area practitioners and doctors of all ages, stages and types of practice. From this parent group we have been able to identify doctors with specific interests and experiences to study and make recommendations on specific subjects to the entire commission for its reactions and further recommendations. This approach has been successful in many cases; but the projects that have *failed* or *faltered* deserve more study to improve the methods for finding better ways to match up ISMA members with the problems of our times and the speculations of the future.

The Subcommittee on Sports and Medicine over the past two years was well on the way to developing an active role for ISMA to relate organized medicine to leadership and ongoing educational roles in health and physical fitness programs for Indiana Schools. Through the process of discussion and reinterpretations of previous CMS, Board and House of Delegates actions and resolutions, the ISMA position was changed to one of endorsing and making a contribution to a newly formed Indiana organization having only minimal relationship with organized medicine. This situation should be regularly reviewed in the coming years and ISMA's position reviewed and possibly revised.

The Subcommittee on Aging has held many well attended meetings to evaluate the need for an Indiana medical organization of non-hospital care institution administrative M.D.'s. Reports to CMS by its able Subcommittee Chairman, Dr. A. Donato, recommended the need to organize this group of M.D.'s into a Subsection of the ISMA. CMS endorses and recommends passage of Res. 78-1 to establish an ISMA Specialty Section of Medical Directors and Staff Physicians of Nursing Facilities.

The Subcommittee on Insurance composed of a small M.D. group with excellent staff support has been able to make realistic evaluations of current ISMA members' insurance programs. The Subcommittee has been particularly active in analyzing the Blue Cross-Blue Shield plans. *Master* policies have been obtained; negotiations and renegotiations have provided our participating members with the best insurance choices possible in the context of inflationary times. These activities have helped to conserve the time of our hard-working Board of Trustees. Because the entire CMS

was at some time involved in the insurance studies, ISMA now has a number of members more knowledgeable in this important area who can serve the Association as a resource in the future. CMS is evaluating new benefit options such as dental and visual indemnification plans.

The interrelationships of medical services, data systems and analyses, ISMA, government medical programs (Medicaid, Medicare, HMO, PSRO, HSA, etc.), are most difficult to organize for evaluation and proper reaction. CMS has studied these interrelationships as a committee of the whole.

PSRO: CMS has recommended technical aspects, such as data operations, should be monitored by an organization such as I-Medic while policy matters such as the development of a Statewide PSRO Council are matters of ISMA concern. *CMS offered the board criteria and possible methods for use in determining nominees to the Statewide PSRO Council.*

HMO: The situation is too fluid. Some states and areas are beginning to organize significant Independent Practice Associations (IP) or HMOs without walls. Continuing study is needed but probably no action or policy position is indicated at present.

MEDICAID: Resolution 77-33 was submitted by CMS with the whereases and resolves giving high priority to data and systems analyses of such non-ISMA data as Medicaid and private usual and customary programs. An appropriation to implement this resolution has not been forthcoming, but rather has been diverted into hiring an attorney with stress on PSRO and HSA and no mention of current data study needs mentioned in Res. 77-33. All of our membership must become aware of the mushrooming effort of the Government to federalize Medicaid completely. This is a multipronged federal effort that can be stymied only by having accurate data analyses. HEW now implies that Blue Shield intermediaries having a predominance of M.D.'s as Board members may be in a position to manipulate provider payments.

This seems rather strange since HEW imposes strict parameters on payments to providers for care rendered to federal beneficiaries. *If ISMA had the analysis available* it would be able to provide our legislators and media with information indicating that while Indiana Medicaid is not *ideal*, it is more efficient, economical and non-manipulated than in most other states. CMS feels for many reasons the implementation of 77-33 with regard to data analysis should be given a higher priority in ISMA affairs.

The Commission spent a fair amount of time evaluating the need for semi-professional spokesmen (M.D.) for specific roles in representing ISMA. This need is developing for some of the following reasons: (1) The number of meetings requiring M.D. professional in-

Reports of Commissions

terpretation and testimony is growing. (2) In-House (ISMA) continuing medical expertise to blend with lay staff talents is becoming desirable if not necessary. (3) More Commissions, liaisons and task forces are being formed that could benefit from ongoing M.D. participation. (4) More bodies such as HSAs, legislative and governmental commissions may require reliable M.D. testimony. CMS has developed some needs for such a program of semiprofessional spokesmen, written job descriptions, and analyzed why we wouldn't or couldn't assume a full or part time organizational position. Financial considerations were particularly evaluated. The results of this effort are embodied in Resolution 78-6 which we recommend passage of as an initial step for development of the concept of semiprofessional staff M.D. spokesmen.

The Co-Chairman undersigned wishes to thank the many active Commissioners who gave of themselves in Commission and Subcommission deliberations. I, for one, have been enriched by the experience of serving and would encourage ISMA members to seek Commission service as a means of serving your patient, organization and discovering yourself.

LEE H. TRACHTENBERG, M.D.

JACK HANNAH, M.D.

Co-Chairmen

WALLACE M. ADYE, JR., M.D.
DONALD DEAN COFIELD, M.D.
EVERETT E. BICKERS, M.D.
ROBERT O. ZINK, M.D.
PAUL E. HUMPHREY, M.D.
ROBERT R. TAUBE, M.D.
ALBERT DAONATO, M.D.
THEODORE R. HAYES, M.D.
GARY BOUGHER, M.D.
R. JAMES BILLS, M.D.
REGINO B. URGENA, M.D.
R. WYATT WEAVER, M.D.
ROBERT R. KOPECKY, M.D.
HAROLD MARSHALL TRUSLER, M.D.
RICHARD B. SCHNUTE, M.D.

Commission on Medical Education

ACTION: Filed.

Three scheduled meetings of the sub-commission on CME accreditation and three scheduled meetings of the full Commission were held at ISMA Headquarters during the reporting period (F.Y. 1978).

1. 1978 marked the beginning of changes in CME accreditation with the AMA and ISMA accreditation authority being assumed by the Liaison Committee on Continuing Medical Education (LCCME). The latter was formed to provide broader representation as an

accrediting agency. The LCCME is composed of representatives of:

The Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, Council of Medical Speciality Societies, Association of Hospital Medical Education, Federation of State Medical Boards in the U.S., Inc., the public and the Federal Government.

Transition from our relationship with the AMA in accreditation to LCCME has been without incident and all of our recommendations for accreditation have been accepted. A delay inherent in the new system contains the potential to diminish physician interest in CME. It can now take six to nine months, after a site survey, for a hospital to be accredited.

2. During the reporting period the following hospitals were "site surveyed" for initial accreditation or re-surveyed for extension of accreditation (asterisk denotes reaccreditation):

Bloomington Hospital*
Terre Haute Union Hospital*
Howard Community Hospital—Kokomo
St. Vincent Hospital—Indianapolis*
Bartholomew County Hospital—Columbus
St. Johns Hickey Memorial Hospital—Anderson
Dearborn County Hospital—Lawrenceburg*
Deaconess Hospital—Evansville*
Reid Memorial Hospital—Richmond*
Mercy Hospital—Elwood*
Ft. Wayne Medical Society Medical Education Foundation, Inc.*

3. Institutions other than hospitals surveyed for CME accreditation were (asterisk denotes reaccreditation):

Ft. Wayne Academy of Medicine and Surgery
Indiana Association of Pathologists*
Wright Institute of Otolaryngology, Inc.*
Aesculapian Society of Wabash Valley—Terre Haute*
Indiana Society of Anesthesiologists*
Hawley Army Health Clinic, Fort Benjamin Harrison

4. All hospitals in Indiana, other than those already having known CME programs, were offered, at no cost, the handbook, "How to Start a CME Program in Your Hospital," prepared by L. S. Stein, Ph.D., of the Illinois Council on CME. Thirty-four hospitals, through their administrator or chairman of medical education, made requests for the book.

5. In a similar action, ISMA Commission on Medical Education sent two handbooks, purchased by the Commission, to all Indiana CME accredited hospitals. These, also issued by Dr. Stein's organization, were titled "Case-Discussion and Problem Solving" and

Reports of Commissions

"Patient-Problem Inventory—Planning CME Programs."

6. Scientific programs of the ISMA state convention were reviewed by the Commission and assigned hour for hour credits for the Physician's Recognition Award. Cards were available at the convention to allow the physician to record the hours of attendance at each accredited program. Cards were subsequently validated and returned to the physician by mail for his CME records.

7. To enable the Commission to be abreast of CME changes, Dr. Eugene M. Gillum was authorized as ISMA's representative to meetings of the National Council of State Committees on CME (NCSCCME).

8. Computerization of CME records for all physicians repeatedly comes to the Commission's attention. AMA has been working on a program for five years, and it is yet to be announced. Several hospitals have computerized records of *their own programs* where they have complete control. ACFP has a computerized program under a limited test in five states. It is encountering many problems, as might be expected.

The Commission was asked for its attitude toward CME computerized records. Its conclusion was that there are grave doubts about such a program, especially its enormous costs. It further concluded that ISMA not attempt to undertake a CME record keeping program until its primary computer program is functioning smoothly and the costs of its operation are well known. At that point, a proposed operations plan, together with cost to the Association and to the individual physicians, should be presented to the Commission for study.

9. Four resolutions were referred to the Commission by the House of Delegates. Action was taken on each and reported back to the Board as closed with action as follows:

77-26 Voluntary CME for ISMA membership—approved;

77-36 Medical Student Component Society—an Ad Hoc committee of the Commission reviewed subject resolution and presented a new resolution to the Commission. The Commission approved the resolution and has forwarded it to the 1978 House of Delegates. Because current bylaws provide that medical student members may be represented in the House of Delegates with power to vote, the Commission is of the opinion that representation should come through the student body of I.U. School of Medicine. It does not preclude the possibility of forming a section at a later date, but the student body would not derive a vote by virtue of

forming a section. A separate component society should not be formed.

Additionally, it is thought that the student council should be considered the executive body with the power to elect delegates and alternates to the ISMA House of Delegates. Designated methods of student delegate election are incorporated in the new resolution;

77-22 Opposition to Medical School Admission—program defeated;

77-53 Instruction in CPR for Physicians—stemming from this resolution, the Indiana University School of Medicine has altered its curriculum. James C. Dillon, M.D. will head a new segment of curriculum to cover CPR in the first year, with a large segment in the second year and a lesser amount in the third. This will embrace not only CPR, but appropriate segments of emergency medicine. Dr. Beering also asked Dr. Dillon to establish two post-graduate courses in CPR.

STEVEN C. BEERING, M.D.
Chairman

CHARLES HACKMEISTER, MD.
DAVID A. BYRNE, M.D.
RICHARD RIEHL, M.D.
GARRE E. BLAIR, M.D.
CLEON SCHAUWECKER, M.D.
JAMES R. LEWIS, M.D.
HUNTER SOPER, M.D.
EUGENE GILLUM, M.D.
T. NEAL PETRY, M.D.
NICHOLAS L. POLITE, M.D.
SHOKRI RADPOUR, M.D.
RONALD SCHEERINGA, M.D.
WALLACE S. TIRMAN, M.D.
ERNEST R. BEAVER, M.D.
FRANKLIN A. BRYAN, M.D.
ROBERT CHEVALIER, M.D.
EDWIN S. McCLAIN, M.D.
JOHN ROSCOE
JOHN PHILLIPS, M.D.
GEORGE ALCORN

SUB-COMMISSION ON ACCREDITATION:

EUGENE M. GILLUM, M.D., CHAIRMAN
W. THOMAS SPAIN, M.D.
MICHAEL A. HOGAN, M.D.
DONALD M. SCHLEGEL, M.D.
WILLIAM FECHTMAN, M.D.
RAYMOND PIERCE, JR., M.D.
WILLIAM D. RAGAN, M.D.
JEFFREY KELLAMS, M.D.
CHARLES HELMAN, M.D.
GARRY BOLINGER, M.D.

Reports of Commissions

STEVEN C. BEERING, M.D.
FRANKLIN A. BRYAN, M.D.
SHOKRI RADPOUR, M.D.
RALPH WILMORE, M.D.
KATHERINE RICHARDSON
LARRY HITCHCOCK, M.D.
JOHN PHILLIPS, M.D.
JOHN ROSCOE
JOHN OSBORN, M.D.
JACK W. PEARSON, M.D.
GLEN BINGLE, M.D.
ROBERT E. LONGSHORE, M.D.

Commission on Public Relations

ACTION: Filed.

The Commission on Public Relations met in September 1977, February 1978, April 1978 and July 1978.

The Commission concurred that the Tel-Med program was one of the best public relations programs ISMA had ever embarked on, and should not be totally cancelled because of cost considerations. It was, however, discontinued in June 1977. A resolution attempting to justify continuance of the program was defeated by the House of Delegates. Since then, the Tel-Med equipment has been on loan to the St. Joseph County Medical Society, supported by funding from the Northern Indiana Health Systems Agency, Miles Laboratories and others. The program is temporarily being run from St. Joseph Hospital, South Bend.

The idea of placing physicians on the news staffs of TV stations to report on medical news was discussed, and the Commission decided that ISMA should encourage county medical societies to pursue this idea. Staff developed a set of operational guidelines for "physician newscasters," which have been distributed to county societies.

The Commission appointed a committee to investigate the possibility of conducting a seminar to identify health care cost problems. However, since the idea was conceived, ISMA formed a Joint Task Force on Health Care Costs. Efforts of the special four-man committee were halted with the understanding that its data would serve as input for the Task Force.

During Fiscal Year 1977 only four speaking engagements were contracted through the ISMA Speakers' Bureau. Nevertheless, the Commission recommended that the Bureau continue to operate. Letters were sent to county medical societies with brochures from Hopkins Syndicate, which handles the program for ISMA; the letters asked societies to publicize the program.

The Commission proposed holding a review hearing session at each of its meeting in 1978 for constructive input from appropriate outside agencies and individuals

regarding any and all areas of medicine and health care services in Indiana that would relate to ISMA. The proposal, however, was rejected by the Board of Trustees.

In 1977 the Indiana State Board of Health had asked ISMA for comments on its Certificate of Live Birth. The Commission recommended deletion of certain unnecessary questions, but the Board of Health virtually disregarded these comments. The chairman of the Commission queried the Board as to why they ignored ISMA recommendations that race and nationality be eliminated from the form on the basis of the individual's right to privacy. Their response indicated this information was for statistical purposes only and is in no way used to identify specific individuals.

The Indiana Right to Life, Inc. asked for ISMA's opinion on its Informed Consent to Abortion. The Commission noted that changes recommended by the Indiana Hospital Association had been almost entirely ignored by the Right to Life, Inc. ISMA legal counsel stated the present State Board of Health form is adequate and recommended not endorsing the Right to Life form. The Commission sent ISMA's official abortion policy to the group, along with a letter explaining that the present State Board of Health form is acceptable. Right to Life did not respond.

Resolution 77-52, "Instruction in CPR in Accredited Schools," was discussed by the Commission each time it met. Initially, the chairman sent a letter to the Superintendent of the State Department of Public Instruction recommending implementation of CPR into the curriculum of all accredited secondary schools in Indiana. The Department's initial response indicated a possible conflict with special interest groups and a possible infringement on local autonomy in school programming. However, the Commission is continuing its efforts at this time.

Resolution 77-54, "Differential Payment," was considered by the Commission following the Board of Trustees' decision to oppose participating and non-participating clauses in all types of contracts. House Bill 1387, introduced by Robert Hayes of Columbus, would prevent insurers from putting such clauses in their contracts. The Commission tabled discussion of this matter pending further legal opinions and other new information.

Although the Commission felt ISMA should support proposed changes to the AMA's Principles of Medical Ethics (to add clarity to the meaning and modernize the language), the Board of Trustees moved to oppose any changes in the principles as presently written.

The Commission supported a plan by MacDonald's of Central Indiana to give a free hamburger to every child who has completed his immunization program. The plan, requiring only that a child have a signed statement from a physician, was implemented in 27

Reports of Commissions

central Indiana counties.

At the suggestion of the Commission, ISMA purchased a TV receiver and video tape player for use at the headquarters. The equipment allows the recording or playback of TV programs or films through the use of 3/4-inch cassettes. Appropriate recordings can be relayed to county medical societies for viewing at hospitals comparably equipped.

The Commission viewed ISMA's new 10-minute IMPAC public relations slide presentation and recommended it for showing at county and district meetings.

The Commission also viewed the color, 16mm film, "The Buck Starts Here," produced by Blue Cross/Blue Shield. It suggests ways for physicians to help contain the costs of medical care. The Commission agreed it would be beneficial to show to physicians around the state. The Commission approved the purchase of a copy of the film for this purpose.

The Commission heard suggestions from Caldwell-Van Riper, Inc., an Indianapolis advertising/public relations firm, on enhancing the physician's public image in Indiana and satisfying the public's appetite for information concerning the health care field. Although decisions on ISMA's approach to an improved ISMA public relations program have not yet been made, suggestions being considered include production of a 10-minute film and a quarterly newsletter. The film would be used for the ISMA Speakers Bureau, and excerpts of it would be used as TV public service announcements. The newsletter, professionally researched and designed, would be targeted toward news media, HSAs, legislators, labor leaders and Chambers of Commerce. Other public relations approaches also are being explored.

The Commission made its selection for the Journalism Awards and for the Physician Community Service Award. These will be presented at the ISMA's annual meeting in October. Nominations for both categories were submitted by county medical societies.

As chairman of the Commission, I wish to thank the members of the Commission on Public Relations for their participation. The meetings were productive and should help enhance the public relations for the Association.

MARVIN E. PRIDDY, M.D.
Chairman

ALBERT S. RITZ, M.D.
THOMAS O. MIDDLETON, M.D.
ROBERT P. ACHER, M.D.
GREG LARKIN, M.D.
RALPH LEWIS REA, M.D.
ROBERT W. HARGER, M.D.
KENNETH AHLER, M.D.
CHARLES D. EGNATZ, M.D.

HARRY G. BECKER, M.D.
ROSS L. EGGER, M.D.
LOGAN DUNLAP, M.D.
GABRIEL J. ROSENBERG, M.D.
MIKE GOLER—Student Member

Commission on Constitution and Bylaws

ACTION: Adoption of the Report and Supplemental Report with the exception of those parts dealing with Resolutions 78-7 and 78-13.

The Commission on Constitution and Bylaws met once on April 15, 1978. There were no changes in the Constitution, however the Commission approved and recommend the following changes which are both administrative and editorial in nature to the structure of the Bylaws.

For clarification, throughout the printed copy of the Bylaws there are words and phrases in parenthesis and underlined. These are the words and phrases to be deleted. Those words and phrases which are italicized are the words and phrases which are recommended for addition.

The Commission on Constitution and Bylaws may meet one additional time for review of amendment resolutions prior to the 1978 I.S.M.A. Annual Convention.

As Chairman I wish to thank all members of this Commission and the staff for their involvement on this project.

BYLAWS:

DIVISION ONE—MEMBERSHIP

Chapter I—Qualifications, Election and Rights

Section 3—Members by Category

Paragraph H

Continued

(Paragraph H. Entire paragraph to be deleted and the following to be inserted.)

H. Inactive Membership. Regular members who decide voluntary inactivity prior to the age of 70 shall be exempt from payment of membership dues for the duration of his inactive status when recommended by the County Medical Society and approved by the Board of Trustees. The inactive member shall receive THE JOURNAL of the Indiana State Medical Association without charge.

DIVISION THREE—BUSINESS AND LEGISLATION

CHAPTER V—House of Delegates

Section 8—Reference Committees and Committee on Rules and Order of Business.

Sub-Section C.

(Sub-Section C. Time and Place of Meetings. Please note the paragraphs in *Italic* are to be added at the end

Reports of Commissions

of the present paragraphs.)

C. Time and Place of Meetings

The time and place of meeting of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

Persons who are not members of the Indiana State Medical Association and seek to appear and present their technical or reference material to the reference committee must receive approval to appear on that specific subject from the reference committee.

Non-Indiana State Medical Association members must register as guests at the committee and be at the call of the reference committee for testimony after which they may be excused from further attendance.

DIVISION THREE—BUSINESS AND LEGISLATION

CHAPTER V—House of Delegates

Section 9—Election of Officers

(Section 9—Election of Officers. 2nd paragraph to be deleted.)

(The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.)

CHAPTER IX—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 8—Duties and Responsibilities

Sub-Section C. The Medical-Legal Review Committee

(Please note the underlined is to be deleted and the words in *italic* are to be inserted.)

C. The (Medical-Legal) *Medico-Legal* Review Committee.

—The (Medical-Legal) *Medico-Legal* Review Committee shall concern . . .

(Proposed Summary to be inserted into the Bylaws.)

D. The Indiana Medical Education Fund Committee. The purpose of this committee shall be to promote, develop and improve medical education in the Indiana University School of Medicine for the general benefit of the entire public by obtaining and using funds from private sources to accomplish that result. The funds collected will be deposited in a trust and at periodic intervals the committee shall make a distribution from the trust to be used by the Indiana University School of Medicine. The Indiana Medical Education Fund Com-

mittee shall consist of eight persons. Five of whom shall be from the Indiana State Medical Association, appointed by the president thereof, all of whom shall be voting members. There shall be three additional members of the committee who shall be ex officio and non-voting and they shall be the Dean of the Indiana University School of Medicine, or his designee, the President of Indiana State Medical Association, and the Executive Director of the Association who shall also act as Secretary of the Committee. The actions of this committee shall be certified to the Executive Committee. Each year a report of the Committee's activities, including a financial accounting report of the fund itself as administered by the trustee, shall be made part of the Executive Committee's annual report to the House of Delegates.

E. The Impaired Physician Peer Review Committee.

—The Impaired Physician Peer Review Committee shall consist of five members selected from Indiana State Medical Association membership whose duty it shall be to develop a program to recognize, treat and rehabilitate physicians who are impaired by neuropsychiatric illness, physical infirmities or alcohol and other substance dependence. The committee will encourage informal and formal referral of impaired physicians through county medical society screening committees. The committee shall be responsible to develop a program in cooperation with the Indiana Medical Licensing Board using as a guide the Medical Practice Act.

DIVISION FIVE—MEDICAL DEFENSE

Chapter XV—Medical Defense Administration, Authority and Procedures

Section 1—Dues Allocation

Section 1—Dues Allocation to be completely deleted. (Section 1—Dues Allocation—One dollar and twenty-five cents (\$1.25) out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.)

Section 4—Custodian of funds to be completely deleted.

(Section 4—Custodian of funds—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Board.)

Reports of Commissions

(Section 5—Annual Report. Words underlined to be deleted.)

—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money (received and) expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

(Section 6—Liability. Words underlined to be deleted. Words in *Italic* to be inserted.)

—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal (defense of) *consultation* for its members as may be incurred in accordance with the terms of these Bylaws.

(Section 7—Eligibility. Word underlined to be deleted. Words in *Italic* to be inserted.)

—The Association shall not undertake the (defense) *consultation* of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Director, shall be considered the only bona fide evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense *consultation* against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services, which are the basis of the suit, were rendered.

JOHN B. GUTTMAN, M.D.
Chairman

THOMAS KANDUL, M.D.
RUSSELL DUKES, M.D.
CLAUDE J. MEYER, M.D.
IVAN T. LINDGREN, M.D.
WARREN MACY, M.D.
C. G. CLARKSON, M.D.
GERALD KURLANDER, M.D.
WALLACE A. SCEA, M.D.
JOHN J. SAALWAECHTER, M.D.
FRANK M. STURDEVANT, M.D.

ROBERT M. BROWN, M.D.
WILLIAM R. CLARK, SR., M.D.
LESTER H. HOYT, M.D.
JOHN RECORDS, M.D.
DON CHAMBERLAIN, M.D., Liaison Representative

Supplemental Report: Commission on Constitution and Bylaws

The Commission on Constitution and Bylaws met one additional time before the annual convention and the following are additional recommendations for implementation in the Bylaws.

For clarification, throughout the printed copy of the Bylaws there are words and phrases in parenthesis and underlined. These are the words and phrases to be deleted. Those words and phrases which are italicized are the words and phrases that are recommended for addition.

BYLAWS:

DIVISION THREE—BUSINESS AND LEGISLATION

Chapter IX—Organization of Activities and Responsibilities

Section 3—Commission Structure

(Please note words underlined and in parenthesis () to be deleted and the words in *Italic* recommended for insertion in the Bylaws.)

(Each Commission will consist of 15 members appointed by the President, with at least one member from each Trustee district.)

The President may appoint one commission member for each 600 active members or major fraction thereof, but in any event, each district shall have one member on each commission. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint (five) members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise. The President shall appoint the chairman of each commission. The commission chairman shall appoint a vice chairman.

Reports of Commissions

DIVISION ONE—MEMBERSHIP

Chapter I—Qualifications, Election and Rights

Section I. Student Members. Medical Students who attend an accredited medical school in Indiana

(Please note the words in *Italic* are recommended for insertion into the Bylaws.)

I. Student Members. Medical Students who attend an accredited medical school in Indiana.

Student members may be represented in the House of Delegates with the power to vote. They shall be entitled to send one delegate or one alternate. Student delegate and alternate are to receive THE JOURNAL of the State Association.

"The Student Council of the Indiana University School of Medicine shall elect a student delegate and alternate delegate from nominees presented to them from each class. All resolutions introduced in the name of the student body must be presented through the Student Council functioning as the executive body of the student members—in effect, a student component society."

DIVISION ONE—MEMBERSHIP

Chapter I—Qualifications, Election and Rights

Section 4—Rights and Privileges of Members

Paragraph C. Rights and Privileges by Membership Category

Sub-Paragraph (c).

(Please note the words in parenthesis () and underlined are recommended for deletion.)

((c) Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XVI of the Bylaws for this coverage.)

Resolution 78-13 was referred to the Commission on Constitution and Bylaws 30 days in advance of the first meeting of the October, 1978, House of Delegates in accord with Chapter XVIII of the Bylaws to insure consideration by the House. Upon reviewing the resolution the Commission noted that the insertion of "Student Loans" in the third paragraph, second resolve, after Section 4, would better clarify the intent of the resolution.

ACTION: *It was voted to recommend insertion of "Student Loans" in Resolution 78-13 so that the second resolve would then read:*

(Please note the words in *Italic* are recommended for insertion.)

"Resolved, that Section 4—Student Loans, of Chapter VIII, entitled "Executive Committee" be deleted and Section 5 be renumbered Section 4; and be it further"

ACTION II: *Resolution 78-13 was approved by the Commission for amendment of the bylaws upon approval by the 1978 House of Delegates.*

DIVISION THREE—BUSINESS AND LEGISLATION

Chapter IX—Organization of Activities and Responsibilities

Section 1—Creation of Committees and Commissions

Please note the listing of committees. It is recommended that the listing of The Medical Legal Committee be changed to read *"The Medico-Legal Review Committee"*.

DIVISION THREE—BUSINESS AND LEGISLATION

Chapter V—House of Delegates

Section 5—Terms

(Please note the words in parenthesis () and underlined are recommended for deletion.)

Unless otherwise provided in these Bylaws, no member of (either a committee or) a commission shall serve on the same (committee or a) commission more than two consecutive terms, but this shall not prevent his serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

DIVISION THREE—BUSINESS AND LEGISLATION

Chapter IX—Organization of Activities and Responsibilities

Section 8—Duties and Responsibilities

(Proposed summary recommended for insertion into the Bylaws.)

D. The Indiana Medical Education Fund Committee. The purpose of this committee shall be to promote, develop and improve medical education in the Indiana

Reports of Commissions

University School of Medicine for the general benefit of the entire public by obtaining and using funds from private sources to accomplish that result. The funds collected will be deposited in a trust and at periodic intervals the committee shall make a distribution from the trust to be used by the Indiana University School of Medicine. The Indiana Medical Education Fund Committee shall consist of eight persons. Five of whom shall be from the Indiana State Medical Association appointed by the president thereof, all of whom shall be voting members. There shall be three additional members of the committee who shall be exofficio and non-voting and they shall be the Dean of the Indiana University School of Medicine, or his designee, the President of Indiana State Medical Association, and the Executive Director of the Association who shall also act as Secretary of the Committee. The actions of this committee shall be certified to the Executive Committee. Each year a report of the Committee's activities, including a financial accounting report of the fund itself as administered by the trustee, shall be made part of the Executive Committee's annual report to the House of Delegates. The five members shall serve staggered terms to insure continuity. Two members shall be appointed to serve three (3) year terms, two shall serve two (2) year terms, and one shall serve a one year term.

(Please note below in *Italic* is the proposed summary recommended for insertion in the bylaws.)

F. Negotiations Committee. The Negotiations Committee shall consist of five physician members appointed for terms of four (4) years each. The initial nomination shall be staggered to insure continuity. Two members shall be appointed to four year terms. One member shall be appointed for a three year term and one member shall be appointed for a two year term and one member shall be appointed for a one year term. The purpose of the Negotiations Committee is to become involved in proposals which affect the practice of medicine that include, but not limited to, negotiating with third parties and various other government agencies at specific direction from the Board of Trustees.

EDITORIAL CHANGE

The following is a recommendation by the Speaker, and Vice-Speaker of the House of Delegates:

That the recommendation from Constitution and Bylaws pertaining to Resolution 77-10—Privilege of Discussion at Reference Committee be amended. That the word "chairman" be added to the end of the third

paragraph, and that in the fourth paragraph the word "committee" be properly changed to read "convention".

DIVISION THREE—BUSINESS AND LEGISLATION

Chapter V—House of Delegates

Section 8—Reference Committees and Committee on Rules and Order of Business.

Sub-Section C.

(Please note the paragraphs in *Italic* are recommended for addition at the end of the present paragraphs, and the words in CAPITALS are the words recommended by the Speaker, Vice-Speaker, of the House of Delegates for addition and editorial change. The italic word that is in parenthesis and underlined> is recommended for deletion.)

C. Time and Place of Meetings

The time and place of meeting of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

Persons who are not members of the Indiana State Medical Association and seek to appear and present their technical or reference material to the reference committee must receive approval to appear on that specific subject from the reference committee CHAIRMAN.

Non-Indiana State Medical Association members must register as guests at the (committee) CONVENTION and be at the call of the reference committee for testimony after which they may be excused from further attendance.

Reports of Committees

Future Planning Committee

ACTION: Filed.

The Future Planning Committee held two meetings, April 12, 1978 and Aug. 9, 1978, both at association headquarters. Additional meetings were arranged but because of the severe winter, and the chairman's almost psychic ability to choose the days of the worst storms, they could not be held.

Resolution 77-9 (Limitation on Holding Major Offices) was referred to the committee by the House of Delegates for action. The resolution read in part, "That the offices of president, president-elect, speaker, vice-speaker, AMA delegates, AMA alternates delegates, and Board of Trustee members be classified as major offices; and be it further *resolved*, That any individual may not hold more than one major position during a given term and he or she must resign from a major office if they attain a second." After extensive discussion, the Future Planning Committee recommends Resolution 77-9 not be implemented.

Resolution 77-14 (Commission Representation) was referred to the committee for action. The president may appoint one commission member for each 600 active members or major fraction thereof, but in any event, each district shall have one member on each commission. After extensive discussion, the Future Planning Committee recommends adoption of Resolution 77-14.

Resolution 77-49 (Commission Restructuring) was also referred to the committee for action. In part the resolution read: *Resolved*, that a possible redistricting plan be investigated and studied by the Future Planning Committee. After thorough discussion, it was the consensus of this committee that Resolution 77-49 is meritorious; however, it will require much information not available to this committee at present. The Future Planning Committee tabled this resolution until the committee has obtained data with which to work. The committee further requested that five or six plans for redistricting be structured for its study based on such factors as physician population, referral patterns, alignment with congressional districts, etc.

At the request of the ISMA's leadership, the Future Planning Committee agreed to assume the task of compiling a list of goals for the association. These will be studied and evaluated by the committee and circulated to the membership for its reaction.

STANLEY CHERNISH, M.D.
Chairman

PETER R. PETRICH, M.D.

JACK SHANKLIN, M.D.

VINCENT J. SANTARE, M.D.

E. HENRY LAMKIN, M.D.

WALTER HUNTER, M.D. (student)

Grievance Committee

ACTION: Filed.

The Grievance Committee has met only once so far this year due to weather problems during the winter and early spring. We anticipate one program meeting before the annual meeting.

Grievances at the time of our meeting in April were similar to those previously noted in prior years—mostly problems relating to communications between the doctor and patient. Seventeen grievances were taken care of during this period of time, and I must commend the physicians of Indiana for their cooperation. We only have one who is not cooperating with this committee.

There have been problems of great depth during this period of time. Most grievances are being handled in a forthright manner.

G. BEACH GATTMAN, M.D.
Chairman

WILLIAM G. BANNON, M.D.

GEORGE T. LUKEMEYER, M.D.

ROBERT E. SNODGRASS, M.D.

Medico-Legal Review Committee

ACTION: Filed.

The Medico-Legal Review Committee had a minimum of internal inquiries submitted to it which were handled by the Chairman with no inquiries requiring committee action.

The Indiana State Medical Association Ad Hoc Committees curtailed activities the Medical Legal Review normally handles, however, the committee chairman strongly endorses the future utilization and continuation of this committee.

The Medico-Legal Review Committee will continue to assist the Association in whatever way possible in solving problems affecting the Legal and Medical professions.

JOHN BEELER, M.D.
Chairman

Medical Education Fund Committee

ACTION: Filed.

Prompted by a change in executive staff leadership, a thorough review of the Indiana Medical Education Foundation was initiated during the latter part of 1976. In January 1977, Dr. Don Wood, chairman of the Indiana Medical Education Foundation Committee, met with the Executive Committee to discuss the need for reorganization of the Foundation's structure so as to insure more positive administrative control and to avoid any future legal complications. With the assistance of outside legal counsel and the cooperation of the Dean of I.U. School of Medicine, a new resolution amending the original resolution that established the Foundation was drafted and presented for the Execu-

Reports of Committees

tive Committee's consideration during the summer of 1977. Essentially, this resolution approved by the Executive Committee:

1) Changed the name of the Committee from the Indiana Medical Education Foundation Committee to the Indiana Medical Education Fund;

2) Established a new committee structure; and

3) Fixed responsibility and reporting.

The amending resolution reads as follows:

Be it resolved, that the committee heretofore known as the Indiana Medical Education Foundation change its name to the Indiana Medical Education Fund;

Be it further resolved, that the committee heretofore structured and known as the Indiana Medical Foundation Committee, or by the shorter title of Foundation Committee, shall hereafter be known as the Indiana Medical Education Fund Committee, or by the shorter title, Medical Education Fund Committee;

Be it further resolved, that hereafter the Medical Education Fund Committee shall consist of eight persons, five of whom shall be from the Indiana State Medical Association, all of whom shall be voting members. There shall also be three additional members of the committee who shall be ex officio and nonvoting and they shall be the Dean of the I.U. Medical School, or his designee; the President of the Indiana State Medical Association; and the Executive Director of the Association who shall also act as Secretary of the committee. A majority of the voting members of this committee shall constitute a quorum for the transaction of business. Applications for funds for medical education and research shall be submitted to the committee by the Dean of the I.U. Medical School accompanied by an explanation as to the specific purposes for which the funds are to be used.

Be it further resolved, that the action of this committee be certified to the Executive Committee and that a full report of this committee's activities as published in THE JOURNAL, including the financial accounting report of the Medical Education Fund itself as administered by American Fletcher National Bank, as trustee, be made a part of its annual report to the House of Delegates.

Be it further resolved, that the President of ISMA shall appoint the five voting members of the IME Fund Committee, including the chairman, for terms of three years to be staggered for continuity purposes.

It is of interest to note that since its inception in 1952, the Foundation (Fund) has disbursed a grand total of \$1,291,462.18 to Indiana University School of Medicine. The present status of the Fund is as follows:

Fund Balance as of 9/30/77: \$354,178.57

Received from AMA-ERF, 3/16/78: \$38,033.86

Fund Balance as of 6/30/78: \$395,832.25

Instructions were given to the trustee (AFNB)

during 1977 to invest the entire Fund in Corporate Bond Fund D (fixed income fund).

DONALD WOOD, M.D.
Chairman

JOE DUKES, M.D.

JACK LOCKHART, M.D.

J. O. RITCHIE, M.D.

JOHN BEELER, M.D.

(Ex Officio) Steven C. Beering, M.D., or
his designee; ISMA President;
ISMA Executive Director.

Committee on Arbitration and Negotiations

ACTION: Filed.

The committee has met three times this year and has advised the following action:

To remove "Arbitration" from the committee's name and function for these reasons: The original intent of the committee was negotiations. Arbitration and Negotiations are antithetical functions. Arbitration functions would usurp functions of other committees. Consequently the committee will notify the Constitution and Bylaws Commission that it feels that "Arbitration" should be removed from the committee name before this committee is inserted into the Constitution and Bylaws.

The committee asked the Board of Trustees to advise longer than one-year tenure on the committee and overlapping of membership. It is felt that this committee needs long term experience without a period of inexperience. This request was referred back to the Commission on Constitution and Bylaws.

The Committee developed its duties as being at least threefold:

To report to the officers, the Board of Trustees, the House of Delegates, and the membership at large actions inimicable to the interest of the ISMA and Indiana Physicians;

To inform other parties of the committee's job of representing the ISMA and Indiana physicians; and

To negotiate specific interests with specific parties upon direction of the officers, the Board of Trustees, and the House of Delegates.

The committee acted upon the following directives from the Board of Trustees and the House of Delegates:

Agreed with the Indiana General Assembly that par-non-par insurance contracts are illegal under existing statutes, notified the Insurance Commissioner of several contracts the committee believes are illegal, assisted the officers in finding specific violations of the above contracts to bring to the attention of the Insurance Commissioner.

Reports of Committees

Discovered that the committee cannot legally (because of "restraint of trade") force insurance companies to semiannually review fee profiles. (Resolution 77 - 32) Alternatively the committee is surveying the ten largest Healthcare insurers in Indiana to determine their policies concerning fee profiles review.

The committee heard reports from ISMA members who attended an advanced Negotiations Seminar in Scotsdale, Arizona.

The Committee is developing a list of "Power Tactics" (a list of social actions which have been used by other groups to accomplish political and social objectives). *Please see attached list.*

The Committee heard Don Crandall, M.D., Chairman of the Department of Negotiations of the Michigan State Medical Society describe the functions of his Negotiations Department. It further asked Doctor Crandall to address the Board of Trustees to which he presented some of the duties and purposes of the Michigan Department of Negotiations. (*Copy of purposes and works attached.*)

The Negotiations Committee is planning to meet one additional time prior to the I.S.M.A. Annual Convention.

I would like to thank members and staff of this committee for all their help and support.

Power Tactics

Strike	Boycott
Withholding of services	Education
Job actions	Negotiations
Paperwork hold-up	Introducing Legislation
Strike fund	Speakers Bureau
Pension fund	Press releases
Elections	Developing candidates
Nominations	Coalition
Public relations (Internal & External)	Non-cooperation
Advertising	Litigation
Lobbying	Writing our own Regulations

PURPOSES AND WORKS OF THE MICHIGAN DEPARTMENT OF NEGOTIATIONS

- I. Purposes
 - A. Negotiate
 - B. Coordinate—Maintain consistent policies and postures.
 - C. The Health Insurance evaluation committee (sub-committee): Establishing criteria of a good health insurance.
 - D. Screens—Profiles—Payment mechanism.
 - E. Presurgical screening program.
 - F. Liaison committees coordinate with the Negotiating Department.
- II. Work of the Michigan State Medical Society Department of Negotiation.
 - A. Original duties
 1. Identification of specific problems amenable to Negotiations.

2. Assembly of all pertinent data and research of problems.
 3. Establishing guidelines.
 4. Negotiation of solution.
 5. Devising of specific action plan.
 6. Coordination of all negotiation activities of the Michigan State Medical Society.
 7. Giving assistance to physicians, medical groups, and communities as requested for negotiating problems.
 8. Education of the membership regarding the use of techniques of negotiations.
 9. At the earliest time possible obtaining authorization from all members of the M.S.M.S. for the Department of Negotiations of the M.S.M.S. be the exclusive bargaining agent for all.
 10. Collect immediately "non-participation proxies" from all physicians to be held in escrow at the M.S.M.S., to be executed in the event of failure at negotiations.
 11. The Department of Negotiation formulate a "Negotiated participation agreement" with third-party payors, which will eliminate for non-participation.
- B. Additional Duties of the Department of Negotiations.
1. Identify research areas.
 2. Monitor data collected.
 3. Monitor all disputes.
 4. Provide liaison with groups in contention.
 5. Consider staff support for above.
 6. Recommend to the council when and where professional arbitrators should be retained.
 7. Recommend to the council the appropriate time for pulling proxies.
 8. Serve as link, with the Medicaid liaison committee; monitor use of plain forms, third party carriers.

ALVIN J. HALEY, M.D.
Chairman

LEONARD NEAL, M.D.
GILBERT WILHELMUS, M.D.
DONALD McCALLUM, M.D.
HERBERT KHALOUF, M.D.
JOHN BEELER, M.D.

Impaired Physician Committee

ACTION: Filed.

Since the last annual report, the Impaired Physician Committee met seven times to finalize the program to be used in Indiana.

The first step taken was to request Eli Goodman, M.D., president of ISMA, to name a 13-member advisory committee which would include a representative from each medical district. It was felt that this advisory committee would provide the local contact necessary to implement the program. The recommendation was accepted and a representative has been named from all but district seven and nine.

Next, the Committee agreed that members of the Advisory Committee should serve as the Screening Committee. Each district advisor was asked to set up the examining panel in his district. The examining committee will be a panel of two or three volunteer

Reports of Committees

physicians, both from the committee and around the state, who are willing to evaluate the impaired physician.

It was the opinion of the Impaired Physician Committee that referrals made to this committee, if treatment is not accepted, should be referred back to the original source. However, the committee felt the final decisions on referral should be made by the president of ISMA, thus alleviating any direct pressure on this committee.

A contact roster was then adopted which will include the date, contact number, initials, county referral source, nature of problem, disposition and follow-up. The contact number will include an "I" or "F" for informal or formal contacts. The referral source will indicate only the generic relationship.

Rick King, ISMA staff attorney, recommended the committee change its name to "Impaired Physician Peer Review Committee" to provide greater protection to the committee and the Association. This has been requested of the Commission on Constitution and By-laws.

The committee also sent a letter to the Medical Licensing Board of Indiana commenting on the Medical Practice Act and giving suggestions as to how this committee could work with the Board in handling the impaired physician.

A brochure was written to explain the Indiana Impaired Physician Program and is being distributed at County Medical Society meetings and to all interested individuals to help introduce the program and explain how it will operate. In addition, members of this committee will attempt to attend district or county society meetings to help educate the physicians around the state about the Impaired Physician and the program of rehabilitation that is now available.

Doctors Gerald P. Johnston, Richard W. Campbell, Wallace R. Van Den Bosch, and Thomas E. Lunsford put on a mini-workshop on confrontation techniques for the advisory committee which was very beneficial.

A two-hour general scientific program was approved by the Convention Arrangements Commission for October 23rd. The speakers selected for the program were: LeClair Bissell, M.D., Director of Smithers Hospital, New York, who will speak on the alcoholic physician; E. Richard Dorsey, M.D., Cincinnati, will speak on the drug dependent physician; and Hugh Hendrie, M.D., Indiana University School of Medicine, will speak on the physician with neuropsychiatric disorders.

The Committee also reviewed a letter sent to Governor Otis R. Bowen, M.D., concerning legislation to control amphetamine drugs and one from the American Association of Medical Society Executives

(AAMSE) proposing guidelines for rehabilitation of medical society executives impaired by alcoholism. The Committee's response to the letter to Governor Bowen was, "The Committee recognizes there is overuse and some abuse of amphetamines, however, believes it should be a matter based on the standards of medical practice and not legislation." The committee felt the AAMSE program was sound and recommended that ISMA make a formal endorsement of the guidelines.

Committee members have received many inquiries about assistance for possible Impaired Physicians, and several physicians have been successfully referred for evaluation and treatment.

I want to take this opportunity to express my appreciation to the members of the committee, and those of the Advisory Committee, for their time and effort in this very worthwhile program.

GERALD P. JOHNSTON, M.D.
Chairman

RICHARD W. CAMPBELL, M.D.
THOMAS E. LUNSFORD, M.D.
WALLACE R. VAN DEN BOSCH, M.D.

Advisory Committee

LARRY SIMS, M.D.
DAVID CRANE, M.D.
CESAR ARCHANGEL, M.D.
ROBERT SEIBEL, M.D.
JOHN ELLETT, M.D.
ALFRED HOLLENBERG, M.D.
L. MARSHALL ROCH, M.D.
HARRY HOLWERDA, M.D.
LAURENCE K. MUSSELMAN, M.D.
GEORGE MANNING, JR., M.D.
ROBERT NELSON, M.D.

Reports of Committees

Supplemental Report: Future Planning Committee

ACTION: Adopted in principle and referred to the Board of Trustees for implementation.

The Future Planning Committee met August 9, 1978 to finalize the future goals and objectives of the Indiana State Medical Association. Following is the list of those goals as submitted to the ISMA Board of Trustees for its consideration and disposition:

I. It is a goal of ISMA to expand and improve services to its members.

- A. Maintain and strengthen relationships with:
 - 1. County Medical Societies
 - 2. Specialty organizations
 - 3. Housestaff physicians, medical students, and medical faculty
 - 4. Group practice associations
 - 5. Organizations of foreign medical graduates
 - 6. Other health-related associations and organizations.
- B. Continue to develop skills in arbitration and negotiations and to develop an ongoing committee to assume an aggressive role in negotiations on behalf of our members.
- C. Update or develop informational materials for our members and county medical society officers which would describe membership benefits and services. These might include:
 - 1. Listing of ISMA administrative personnel and their areas of responsibility.
 - 2. Listing of ISMA activities.
 - 3. ISMA Quick Reference Guide to policies of the Association.
 - 4. Listing of services available to county society officers from ISMA headquarters.
 - 5. Speakers Bureau listing.
 - 6. Membership benefits.
 - 7. Listing of resource materials available from ISMA and AMA.
 - 8. Methods of effecting ISMA policy through commissions, committees, Board of Trustees or House of Delegates.
- D. Expand and improve ISMA's ability to sense needs of membership.
- E. Establish a viable housestaff-resident section of ISMA.
- F. Develop health manpower and membership data bank.

II. It is a goal of ISMA to improve and strengthen our activities dealing with state and federal legislation and governmental agencies.

- A. Establish ISMA commission/committee staff re-

sponsibilities for surveillance of state legislation, federal legislation, and governmental regulatory agencies.

- B. Develop a central data bank on health related issues to assist officers in preparing testimony, and to assist legislators in drafting legislation and presenting testimony.
- C. Develop a visitation program for Congressmen in Washington and at their home district offices, key state legislators, and governmental regulatory agencies as appropriate.
- D. Develop and maintain a comprehensive profile on each legislator as well as a tabulation of their voting record on health legislation.
- E. Develop a keyman program or a key contact program for state and federal legislators.
- F. Develop a program to assist physicians who are serving on committees and boards of governmental agencies.
- G. Strengthen lobbying activities at state and national levels.
- H. Strengthen and expand IMPAC and coordinate its activities with the Association's legislative activities.
- I. Increase surveillance of governmental agencies and their intrusion into medical practice.

III. It is a goal of ISMA to improve communications with members and the public which they serve.

- A. Communications to the membership should be improved covering items of general interest, legislative and political activities and organizational activities.
- B. THE JOURNAL content should be expanded to include articles of socioeconomic interest.
- C. Improve the public relations of organized medicine.
- D. Assume a more active role in the dissemination of information on health matters, public health, education, patient education to schools and the general public.

IV. It is a goal of ISMA to improve its organizational structure and to better control its commitment of resources.

- A. Maintain sufficient funds in reserve for at least one year's operation.
- B. Identify and explore the development of sources of income in addition to dues.
- C. Develop zero-based program budgeting and periodically evaluate all association programs.
- D. Assess the needs of the headquarters and plan for an orderly growth of its physical plant requirements.

CONTINUED ON PAGE 1217

Report of Ad Hoc Committees

Ad Hoc Committee on Improvement of Medical and Health Care in Jails

ACTION: Filed.

Inadequate medical care in jails has been a long standing problem for the criminal justice system in this country. Within the past few years, this problem has been the subject of many legal suits. Generally speaking, judges throughout the country have been findings that prisoners have a constitutional right to adequate medical care. In the words of an Arkansas circuit court judge, "If Arkansas is going to operate a penitentiary system, it is going to have to be a system that is countenanced by the Constitution of the United States."

Recognizing the need for national direction with this problem, the American Medical Association applied to the United States Justice Department's Law Enforcement Assistance Administration for a grant to develop health care standards for jails across the country. In 1976, the American Medical Association sub-contracted with the state medical associations in Indiana, Georgia, Maryland, Wisconsin, Michigan and Washington. The project was designed to take three years, with the first year being devoted to development and testing of standards. The second year was designed for implementation and further testing of standards in select pilot jails. The third year was designed for expansion of the project into non-pilot jails.

Since last year, the Indiana State Medical Association has helped design health care delivery systems in the Marion, Greene, and Monroe County jails that have resulted in AMA Accreditation of those jails. The project has already begun to expand to additional jails in Indiana and within the last few months the health care delivery systems at the LaPorte, Allen and Vanderburgh County jails have also been accredited. ISMA staff are currently accepting applications from additional new jails and plan to accredit an additional ten jails during the coming year.

In cooperation with the Indiana Sheriffs' Association, a series of regional seminars was held with sheriffs around the state, discussing the medical/legal implications of jail health care. Jailers from around the state of Indiana recently participated in a four-day jail health care workshop jointly sponsored by the Indiana State Medical Association and the Indiana Sheriffs' Association. The workshop was the first of its kind to be offered in the country and received national publicity.

Under the direction of Dwight Schuster, M.D., Medical Director for the ISMA jail program, the Indiana Jail Project is progressing on schedule. Additionally, Doctor Schuster authored a nationally publicized monograph entitled "The Recognition of Jail Inmates with Mental Illness, Their Special Problems and Needs for Care."

At the present time, it appears that significant progress has been made in improving medical care in county jails throughout the state of Indiana. The project appears to have had a ripple effect into jails that have had no direct contact with ISMA personnel.

During the past year, the project has received favorable attention from the news media throughout the state of Indiana. Most recently, Doctor Schuster and an E.M.T. from the Marion County jail were featured in a Channel 13 (Indianapolis TV) report.

DWIGHT W. SCHUSTER, M.D.
Chairman

MICHAEL J. HUNTLEY
Project Director

Ad Hoc Committee on Computed Tomography

ACTION: Filed.

The Ad Hoc Committee on C-T was continued for a second year at the request of the President with the task of monitoring the many issues developing in the field of high cost technology, specifically computed tomography. The Committee is to investigate and make recommendations to ISMA regarding areas they deem require special attention.

Response in opposition to initial Federal Guidelines for C-T was made and resulted in little change by HEW. Cost containment rather than quality care seemed HEW's only concern.

On Dec. 14, 1977, the NIHSA held a public hearing on recommended Criteria and Standards for C-T, to be used as the basis for determining necessity of and requirements for operation of C-T in northern Indiana and perhaps the entire state. Delay was requested and granted on the basis of numerous errors in the document. The members of this committee were apprised of the document and they were asked to provide appropriate suggestions and improvements. The major issues not addressed by this document included (1) the quality of C-T studies, (2) referral, C-T operation and ownership, and utilization review by the same individual, (3) non-approved and mobile scanners and their impact on institutional units. This committee recommended excellent changes to the original document as well as follow-up draft revisions. Many changes resulted in a more understandable and practical set of Criteria and Standards for C-T acquisition.

HEW, through the health planning agencies, will direct their attention to other areas of high cost technology now that the C-T guidelines are developed. This Ad Hoc Committee has completed its intended tasks. It is recommended that ISMA have, on standby, lists of willing and knowledgeable experts in various fields including C-T to be called upon on short notice to respond to important issues as they arise.

Reports of Ad Hoc Committees

The Chairman wishes to commend the committee for their many excellent recommendations and efforts on these matters for the past two years.

DONALD S. CHAMBERLAIN, M.D.
Chairman

L. RAY STEWART, M.D.
ROSCOE MILLER, M.D.
RAYMOND GIZE, M.D.
DAVID GOLDENBERG, M.D.
JOHN JOYNER, M.D.
EVART BECK, M.D.
JAMES L. GRAINGER, M.D.
ROBERT R. NELSON, M.D.
DAVID E. WHEELER, M.D.

Ad Hoc Committee on Immunizations

ACTION: Filed.

The Ad Hoc Committee on Immunizations did not meet because there was no action required by this committee.

However, the chairman with the approval of the other members did put together a fact sheet relative to the immunization levels in Indiana as rebuttal to the HEW claims. This fact sheet was then provided to the ISMA Auxiliary as background information in re-writing the AMA promotional material on immunizations to reflect the Indiana picture. In addition, the fact sheet was used as the basis for another press release titled, "Continuing Immunization Program Not Necessary," and was also provided to the Indiana Academy of Pediatrics and the Indiana State Board of Health Immunization Action Committee and the Indiana Academy of Family Physicians.

The chairman believes the need for this Ad Hoc Committee is still viable and would hope that it is kept intact.

ROBERT L. PARR, M.D.
Chairman

IVAN LINDGREN, M.D.
RONALD RHODES, M.D.
LAMBRO DIMITROFF, M.D.
ROBERT SEIBEL, M.D.

Ad Hoc Data Processing Steering Committee

ACTION: Filed.

In order to oversee the development of ISMA's computer capability, your Association's President, Dr. Eli Goodman, appointed an ad hoc Data Processing Steering Committee and requested me to serve as Chairman. The Committee has had four meetings and

will meet once more before the ISMA annual convention.

At its initial meeting, the Committee reviewed its charge and agreed that its responsibilities included:

1. Overseeing and approving the design of ISMA's new membership system;
2. Approving any additional computer applications made possible as a result of an expanded capability;
3. Approving all systems logic and procedures to be used in data collection;
4. Establishing and approving all policies governing the collection, storage, retrieval and release of data; and
5. Studying the feasibility of establishing a medical data center to monitor the quality of care delivered in ambulatory settings.

Initially, the Committee was provided with a update on the various computer application projects with which ISMA is involved.

The proposal to the Medical Licensing Board of Indiana to automate its records and procedures will probably not be implemented this year due to a lack of funding on the part of the Medical Licensing Board. There was no provision made in the Bowen Administration's budget this year for such services. Moreover, the Administration will encounter difficulty in justifying computerization for just the one Board (Medical Licensing Board).

The Committee discussed at length the data items presented by ISMA staff to be components of the ISMA physician data base. Accordingly, the Committee approved for incorporation into the new ISMA data base those data items presently part of the AM-CAP file as well as those data items that are presently part of the AMA file or part of existing ISMA records. The Committee agreed that further determination be made as to what items should be added to the data base in logical segments so as to avoid excessive computer programming. County medical society executives were also given an opportunity to suggest items to be included in the ISMA system that might be unique to their society's data requirements. In this connection, the Committee also approved the newly designed billing form for the ISMA computerized membership system contingent upon further discussion with AMA staff to insure compatibility with the criteria established for the AMA's 1979 direct billing program.

The issue of ISMA's involvement in facilitating the data processing applications of Indiana's PSROs was considered by the Committee. The Committee approved the principle of ISMA's involvement in meeting the data processing requirements of the various Indiana PSROs. The Committee felt that such an active role on the part of ISMA does not appear to be in conflict with ISMA's policy on PSRO as it would enable ISMA to better protect the confidentiality and release of phy-

Reports of Ad Hoc Committees

sician-generated data in addition to providing ISMA with the capability of refuting and validating government reports.

The Committee discussed the concept of forming an ISMA Foundation for Medical Care in order to accommodate all future ISMA computer applications. Staff made contact with state medical societies in Colorado, Texas, and Georgia—all of whom have active medical care foundations. It was pointed out, however, that there may be some difficulty at the present time in obtaining an IRS foundation classification (501 C-3) since the entire matter is currently being studied by government. The Committee was reminded that I-MEDIC had been established several years ago [as a ISMA not-for-profit corporation] for the express purpose of providing a mechanism for ISMA involvement in PSRO data collection and processing and other computer applications. Although I-MEDIC has been incorporated as a not-for-profit corporation, ISMA never applied for an IRS classification determination. It was suggested that perhaps I-MEDIC could be activated to function as a contracting party with outside groups, such as PSROs, and that I-MEDIC in turn could purchase its required data processing services from ISMA. As a result, ISMA legal counsel was requested to research the status and potential use of I-MEDIC as a mechanism for accommodating future ISMA computer applications.

Following discussions between ISMA legal counsel and representatives of the George S. Olive Company, it was recommended that I-MEDIC, if to be used at all, be converted to a for-profit corporation. The IRS has recently been according close scrutiny to non-profit associations establishing not-for-profit corporate entities to accommodate unrelated activities. It was further recommended that ISMA own all of the stock in I-MEDIC in order to ensure control of its activities. As a result, I-MEDIC was recently converted to a for-profit corporation.

Contracts were executed with the Board of Health which provided for the collection of information and submission of summary reports by ISMA on the availability and delivery of certain specialized health services such as: diagnostic radiation, therapeutic radiation, cardiac care, outpatient services, emergency services, and computed tomography. The methodology for collecting the information consisted of mailed questionnaires and personal visitations to some of the largest hospitals in the state. This was done with the knowledge of the Indiana Hospital Association but without its official participation. Results of the survey have been most gratifying, with responses received from approximately 80% of the 126 hospitals included in the study.

The Committee expended considerable time and ef-

fort in studying and investigating the AUTOGRP computer system for possible use by I-MEDIC in satisfying the data processing needs of Indiana PSROs, should I-MEDIC be selected as a data processor. The AUTOGRP system is an interactive computer system developed at Yale University under a grant from HEW to enhance the capabilities of PSROs in the areas of quality assurance and utilization review. Since ISMA's present computer system does not have the technical capability to meet PSRO data requirements, the Committee endorsed I-MEDIC's use of the AUTOGRP system in developing proposals for data processing services to PSROs. Responses to Requests for Proposals (RFPs) have been submitted by I-MEDIC to Area V PSRO and responses are presently under preparation for several other PSROs that recently achieved conditional status.

JAMES GOSMAN, M.D.
Chairman

ALVIN J. HALEY, M.D.
ARVINE POPPLEWELL, M.D.
STANLEY CHERNISH, M.D.
PETER R. PETRICH, M.D.
THOMAS A. GEHRING, M.D.
H. MARSHALL TRUSLER, M.D.

ACTION: Filed. The chairman, the commission and the committees were highly commended for the 129th Annual Convention program.

COMMISSION ON CONVENTION ARRANGEMENTS: Thomas A. Neathamer, Jeffersonville, chairman; Stanley M. Chernish, Indianapolis, vice-chairman; Eugene Austin, Evansville; James N. Topolugus, Bloomington; Richard McIlroy, Columbus; Fred Haggerty, Greencastle; James Johnson, Richmond; Thomas W. Alley, Indianapolis; Clarence Asburn, Muncie; Max Hoffman, Covington; Daniel T. Ramker, Hammond; Shirley T. Khalouf, Marion; Thomas A. Felger, Fort Wayne; Glen McClure, Sullivan; Fred Adler, Munster; Victor H. Muller, Indianapolis; Mrs. James Koontz, Vincennes, Auxiliary Liaison.

GOLF TOURNAMENT: Clemente F. Oca, Jeffersonville, chairman.

TENNIS TOURNAMENT: Gordon L. Gutmann, Jeffersonville, chairman.

SCIENTIFIC EXHIBITS: George T. Lukemeyer, Indianapolis, chairman.

AUXILIARY AND WOMEN'S ACTIVITIES: Mrs. Everett E. Bickers, Floyds Knobs, chairman; Mrs. Joseph Mudd, Clarksville, co-chairman; Mrs. Joseph Bruckman, New Albany, treasurer.

Reports of Trustees

First Trustee District

ACTION: Filed.

The annual meeting of the First District Medical Society was held at Evansville Country Club on Thursday, May 18, 1978, and 153 doctors and their wives turned out for the occasion. Many guests were in attendance, including the following representatives of the Indiana State Medical Association: Dr. & Mrs. Eli Goodman, Dr. James Harshman, Dr. Lloyd Hill, Dr. Martin O'Neill, Dr. Arvine Popplewell, Mr. Don Foy, Mr. Ron Dyer, Mr. Mike Huntley, and Mr. Mark Miles. Mr. Jerry Martin was present representing Indiana Blue Shield, and Dr. Bernard Rosenblatt introduced his son, Dr. Randall Rosenblatt.

Lively entertainment was provided during the cocktail hour by Vintage Red, a Dixieland jazz band from Bloomington, which brought the crowd to its feet with their rousing Dixieland rendition of the Indiana University fight song.

Dr. James Marvel, First District president, announced that ISMA field man, Bob Amick, would soon retire, and thanked Bob for his 26 years of service to the physicians of southern Indiana. Dr. Tom Clark, chairman, presented trophies to the winners of the 1978 Bob Acre Memorial golf tournament. They were Dr. Jim Heinrich, who took low net with a gross of 77 and a net of 72, and Dr. Dennis Hodge, who won low gross with a round of 76.

Those present were most interested in the report of Dr. Ralph Carlson, Indiana Blue Shield Trustee from the First District. Dr. Carlson reported that Blue Shield was under attack by three different governmental entities: the Federal Trade Commission, the Indiana Insurance Commission, and the Moss Subcommittee of the United States Congress. He detailed charges made by the Insurance Commissioner and concluded with the observation that he could not predict how these difficulties would be resolved.

Dr. Albert Ritz, First District representative on the ISMA Commission on Public Relations, urged those present to work harder at getting the facts about health care costs before the public. To this end, he recommended use of the ISMA bureau of non-physician public speakers.

A report on the American Medical Association was presented by Dr. Patrick Corcoran, AMA Delegate, who emphasized that AMA is moving vigorously against federal regulatory agencies which seek to infringe upon the practice of medicine. Dr. Corcoran noted that AMA is currently investing \$50,000 a month in the defense against FTC, alone.

Dr. Fred Smith, District IMPAC representative, introduced the IMPAC staff liaison with ISMA, Mr. Mark Miles, and everyone enjoyed the excellent audiovisual show he subsequently presented. Other business

included a request from Dr. Gilbert Wilhelmus for support of Dr. Joe Black's candidacy for re-election to the Indiana University Board of Trustees. New First District officers elected at the meeting are Dr. Forrest Radcliff, president, Dr. Frank Hilton, vice-president, and Dr. William Wells, secretary-treasurer. The date chosen for the annual meeting in 1979 is Thursday, May 17.

Last year the First District sponsored a caucus and hospitality room at the state convention for the first time, and it worked so well that our delegation has decided to follow the same procedure in Clarksville this fall.

I am deeply indebted to the officers and ISMA commission members from the First District who worked hard all year to represent us at the state level, and I am especially grateful to Dr. DeVerre Gourieux, my alternate, who so graciously filled in for me at those meetings of the Board of Trustees which I was unable to attend.

JOHN BIZAL, M.D.
Trustee

Second Trustee District

ACTION: Filed.

For the past year we have remained rather dormant, quietly going about our business and with little accomplished with little to stimulate our association.

Apparently there is little threat, at present, regarding government imposition on health care delivery. One must assume that the present administration in Washington is good for medicine. They are either too broke or too divided in their opinions to be a real threat to our fraternity.

I can envision in the coming months some good fights and stimuli arising from (1) our relationship with the Blues and (2) our concern with the ever-menacing HSAs and PSROs. This is my swan song—my best to all.

PAUL W. HOLTZMAN, M.D.
Trustee

Third Trustee District

ACTION: Filed.

Of interest during this past year to the members of the Third District Medical Society was the action taken on Resolution 77-2 entitled "OPPOSITION TO NATIONAL HEALTH INSURANCE."

Introduced by the Clark County Medical Society in the 1977 House of Delegates, the resolution requested the ISMA Board of Trustees to poll all ISMA members as to whether or not they want the AMA to withdraw their bill for comprehensive health insurance and vigorously oppose any AMA comprehensive health insurance bill.

Reports of Trustees

The resolution further asked that the ISMA ask all other state associations to do the same with their memberships and that, if those polls reveal that the majority of physicians are of like mind, then prepare and submit a resolution to the AMA instructing the AMA to follow the dictates of its membership.

The poll was taken by the ISMA and on the first question—"Should the AMA withdraw its bill for comprehensive health insurance?"—337 answered YES and 341 registered a NO vote.

On the question "Should ISMA oppose any form of AMA comprehensive health insurance bill?," 300 reported YES and 371 said NO.

The total vote on the questions comprised 15½ % of ISMA dues-paying members.

Results returned from other state medical associations included North Carolina, Colorado, and California, which voted with the majority of Indiana votes, i.e., NO and Kansas voted YES.

As usual I have attended most of the Board of Trustees' meetings and will continue to do so, keeping the District's views in mind.

THOMAS A. NEATHAMER, M.D.
Trustee

Fourth Trustee District

ACTION: Filed.

The Fourth District had its annual meeting at Madison, Ind., May 24, 1978. At the afternoon meeting Dr. Jack Hague spoke on "New Approaches to the Treatment of Arthritic Pain." The presentation was well received. At our business meeting in the afternoon, Dr. Alvin Henry of Columbus was re-elected Blue Shield representative, Dr. Brockton Weisenberger of Columbus was elected president of the Fourth Medical District, Dr. Mark Bevers of Seymour was elected vice-president and Dr. William Cooper of Columbus was elected secretary-treasurer. At the evening meeting Dr. William Salter of Adelaide, Australia spoke on "Medical Delivery System in Australia." This was a very informative and enjoyable speech and again was well received by all present.

The Fourth District wishes to thank the officers and other trustees and the staff of ISMA for attending the district meetings. The Fourth District medical meeting in 1979 will be held in Columbus, Ind. at a date to be determined.

HOWARD C. JACKSON, M.D.
Trustee

Fifth Trustee District

ACTION: Filed.

With the annual meeting of the ISMA in October comes the termination of my second term as trustee of the District. I will have served five years as alternate

trustee, and six years as trustee. That seems like an awfully long time, but in all sincerity, I consider it one of my finest learning experiences.

First, I hadn't previously realized the extremely high quality of the people who serve the membership as trustees, delegates, members of the various commissions, AMA representatives, etc. Secondly, I learned just how democratic the AMA really is. Each county picks its delegate(s), and he/they choose the representatives to the AMA. It could not be more democratic than that. I have heard much criticism of the AMA as you have, but I can assure you, the delegates from Indiana were 100% representative of those who elected them. The trustees received copies of their voting record, and it is certainly something to be proud of. Of course in this area of the U.S., we have a conservative viewpoint, and that is the way our delegates voted. Unfortunately, there are just more doctors in some of those areas of the country who do not have such conservative viewpoints.

The number of delegates to the AMA is based on the number of physicians of the individual state, and some of the states with the more liberal viewpoint just happen to be more heavily populated, and hence have more physicians, and hence more delegates to the AMA. As a result, the conservative viewpoint was outvoted; but our delegates cannot be blamed for this. There are those who maintain that the world is changing and the conservative outlook is no longer correct; I happen not to agree. I am firmly convinced this trend toward socialism and bigger and bigger government is not the right road; unfortunately, at the present time, I belong to a minority viewpoint on this subject, not only among doctors across the country, but the people who elect our government officials also seem to have convinced the majority of citizens that socialism is the wave of the future.

But, I still don't think we should abandon the AMA and join some other organization that happens to be more vocal at this moment; we have a very democratic organization and I think the proper course for those of us who believe as I is to work even harder to increase the membership in this organization, make it even more powerful and try to convert some of our fellow physicians to our way of thinking. Always remember the basic fundamentals that made our profession the great profession that it is, and those same fundamentals that made this country the great country that it is—these did not originate in Washington; they originated from the people.

The Fifth District meeting was held at the Allendale Country Club in Terre Haute, Wednesday, May 3, 1978. Dr. Franklin Swaim presided. The scientific session was put on by the Indiana Academy of Family Physicians—an excellent program. The business meeting started at 4 p.m. We had an excellent representa-

Reports of Trustees

tion of the "official family" including Dr. Martin O'Neill, chairman of the Board; Dr. Eli Goodman, president of the ISMA; Dr. James Harshman, president-elect; Dr. Arvine Popplewell, treasurer of the ISMA. Also present were the following staff members of the ISMA: Don Foy, executive director; Mike Huntley, field representative; Bob Amick, field representative who retired this year, and who did a very outstanding job these many years; Ron Dyer, staff attorney; and Rosanna Iler, membership activities.

The following officers were elected:

Dr. Paul Siebenmorgan, trustee of the Fifth District;
Dr. Jauw B. Kho, M.D., Terre Haute, president of the Fifth District;

Dr. Clyde W. Jett, re-elected secretary-treasurer.

The next meeting will be at Terre Haute May 9, 1979.

Following the dinner, attended by approximately 90 persons, Doctor Bowen gave an excellent talk.

Again my thanks to each and every one of you for allowing me to be your Trustee, and my best wishes go to Dr. Paul Siebenmorgan, your new Trustee.

CLEON M. SCHAUWECKER, M.D.
Trustee

Sixth Trustee District

ACTION: Filed.

The Sixth District sustained a significant loss in dedicated leadership earlier this year with the death of trustee Glen Ward Lee. Dr. Lee was beginning the second year of his three-year term when he died suddenly while on vacation in Florida. He had served as alternate trustee when Paul Inlow was trustee during the previous three years. I recall Dr. Inlow's remarks about Dr. Lee in reference to his sincere attention to ISMA Board of Trustee business even as an alternate.

Since Dr. Lee's death, I have attempted to fill his shoes, having been appointed by the Board of Trustees to serve his unexpired term. I contacted each county medical society president by letter in July. I intend to keep in touch with them concerning local feelings on important ISMA considerations. It is also my intention to carry out the personal visitation requirement.

In May the Shelby County Medical Society hosted the Sixth District Medical Society's annual meeting. All county medical societies within the district were represented at the afternoon business session. Dr. Hal Rhyneason, president of the Sixth District, presided. The ISMA staff and Executive Committee were present and contributed to the business discussion. Dr. Malcolm Scamahorn, AMA delegate, was also present and discussed his representation at the upcoming AMA annual meeting.

Officers for the coming year will be Dr. Rhyneason, president; James M. Lorber, vice-president; Douglas Morrell, secretary-treasurer; Dan Hibner, Richmond, alternate trustee.

The Sixth District's 1979 meeting will be held at Rushville with the Rush County Medical Society as host.

D. W. ELLIS
Trustee

Seventh Trustee District

ACTION: Filed.

The Seventh District Medical Society's 1978 meeting was held June 14 at the Valle Vista Golf Resort. The well-attended meeting was chaired by Seventh District President, Dr. William C. Stafford.

Following acceptance of the Secretary/Treasurer's reports, an opportunity for brief comments was provided to Dr. Eli Goodman, President, Indiana State Medical Association, and to Dr. James A. Harshman, President-Elect, Indiana State Medical Association. Also introduced were Dr. Lloyd L. Hill, Speaker, ISMA House of Delegates; Dr. Martin J. O'Neill, Chairman, ISMA Board of Trustees; Dr. Arvine G. Popplewell, Treasurer, ISMA; Dr. Joseph F. Ferrara, Assistant Treasurer, ISMA; and Mr. Don Foy, Executive Director, ISMA. Mr. Foy introduced the ISMA staff in attendance.

A break in the routine agenda items provided the opportunity for the presentation of a plaque to Mr. Robert J. Amick on the occasion of his anticipated retirement as ISMA Field Representative. The plaque read "Presented to Robert J. Amick from the Seventh District Medical Society in recognition of his dedication and service to the physicians of Hendricks, Johnson, Marion and Morgan Counties, presented this fourteenth day of June, 1978." In his comments, Mr. Amick took the opportunity to encourage the members to stick together, especially politically.

Elections were then held for the Seventh District officers and resulted in the selection of Dr. M. Max Wesemann to succeed Dr. Stephen L. Hardin as President-Elect, and Dr. Malcolm O. Scamahorn to succeed himself as Secretary/Treasurer. Also elected to succeed himself was Dr. John G. Pantzer for a three-year term as Seventh District Trustee.

Following the business meeting, the district members adjourned to join their guests for cocktails and dinner, followed by a presentation by Professor Henrich.

DONALD C. MC CALLUM, M.D.
JOHN G. PANTZER, M.D.
Trustees

Reports of Trustees

Eighth Trustee District

ACTION: Filed.

Since a review of transactions of the ISMA Board of Trustees is available elsewhere, this communication to the membership of the Eighth District will not undertake such a report. Also a chronicle of the activity of your trustee at Board meetings would be unwieldy. Let me summarize in this way:

Members of the Eighth District Medical Society, comprising the medical societies of Jay County, Randolph County, Madison County and Delaware-Blackford County, are generally conservatively disposed philosophically, and it has been my effort to represent the district and its views at the ISMA Board of Trustees. Sometimes such views prevail and sometimes they do not, but they are always presented.

The subjects of overriding importance to physicians in the Eighth District are those concerning deterioration of good medical practice due to federal government intervention. Thus the implementation of PSRO, establishment of HSA regulations, national health insurance, and a host of proposed federal laws and regulations are regularly opposed. Also our representatives at the AMA are urged to maintain a conservative posture. Support is given to all Board proposals and AMA activities that foster better standards of medical practice, protect medical and economic freedoms of physicians and patients, and promote high standards of medical practice.

The members of the Eighth District Medical Society enjoyed meeting together June 7, 1978 at the Green Hills Country Club in Delaware County. The meeting was hosted by Randolph County Medical Society, and Dr. Lowell Painter served as president, with Dr. H. W. Koch as secretary. Paul Page, The Voice of the 500, entertained at the dinner meeting. Officers for 1979 for the Eighth District were elected and the Jay County Medical Society was selected as the host for the 1979 meeting.

JACK M. WALKER, M.D.
Trustee

Ninth Trustee District

ACTION: Filed.

The 1978 Ninth District meeting was held in Lafayette, hosted by Hamilton County. Dr. Earl Butz, former U.S. Secretary of Agriculture, was the speaker. His topic was, "Good Government is *Your Business*." The dinner and presentation were well attended, but only 14 Ninth District members attended the business meeting (only seven of these were not elected officers or involved in planning the meeting).

The 1979 meeting will be hosted by Tippecanoe. I urge all Ninth District members to re-examine their

schedules to determine if they can devote slightly more time to involvement to non-medical aspects of medical practice. Please plan to attend the 1979 meeting.

I visited approximately one-third of the county societies this year, and I received some good input at each meeting. The main concerns of the members with whom I spoke seemed to center around the increase of government involvement in medicine and the relationship of ISMA to the third-party carrier. There is even some hint that members are questioning whether the third-party carriers are more interested in their relationship with the government and industry than they are in serving their individual clients (the patients).

At any rate, the ISMA Board of Trustees has spent much of its time this year discussing the problems of government involvement and our relationship with third-party carriers. Please give us your formal and/or informal input on these, or any other, matters that are problems in each of your areas.

I am very pleased to be the Ninth District Trustee, and once again thank you for this opportunity. Please assist the ISMA Board of Trustees by attempting to allot more time for involvement in the non-medical matters that affect medical practice.

JOHN A. KNOTE, M.D.
Trustee

Tenth Trustee District

ACTION: Filed.

The Tenth Medical Trustee District consists of Lake and Porter counties, in northwest Indiana, and contains approximately 600 ISMA members. Both counties are actively seeking the membership of physicians practicing in the area who are not presently affiliated with their County and State Medical Associations. This is being done by citing the benefits of membership. AMA membership is highly recommended.

The last annual meeting of the District was held May 31, 1978 at Lake of the Four Seasons, near Valparaiso. District President, Dr. James Brown, Valparaiso, conducted the meeting. The minutes of the October 1977 meeting were read and approved. At that meeting Dr. Martin J. O'Neill, Valparaiso, was re-elected Trustee. Dr. O'Neill, also Chairman of the ISMA Board of Trustees, made the annual Trustees report. He said that at the AMA annual meeting in St. Louis, in June 1978, some principal items on the agenda would be revisions in the AMA Principles of Medical Ethics, cost containment, and the payment for second surgical opinions by insurance carriers. All these issues have been discussed at ISMA Board meetings and the ISMA Delegates to AMA are aware of the Board's feelings. He said the State Association, along

Reports of Trustees

with the Indiana State Hospital Association, has developed a statewide commission to study health care costs. There are representatives of labor, industry, insurance, and government on this commission.

Dr. O'Neill appealed for increased physician input and participation in the Health Systems Agency organizations. He announced that the ISMA poll on the AMA's National Health Insurance Plan showed the Indiana physicians are in favor of AMA's involvement, but about evenly divided on the present AMA plan. Dr. O'Neill said that one of the principal subjects currently being studied by the ISMA Board is the Association's participation on the Blue Shield Board of Directors, and said that this subject will also be an important item in the House of Delegates meeting in October. He discussed the recent visit of ISMA officials to Washington, and said the reception given by the Indiana Congressmen, Senator Lugar, and Senator Bayh's staff was the warmest ISMA ever received.

Dr. Brown introduced the following guests:

Dr. Eli Goodman, ISMA President;

Dr. James Harshman, ISMA President Elect;

Dr. Lowell H. Steen, AMA Trustee;

Dr. Leonard Neal, Alternate-Trustee tenth District;

Dr. Arvine Popplewell, ISMA Treasurer;

Dr. Lloyd Hill, ISMA Speaker of the House of Delegates;

Dr. Larry Allen, Vice-Speaker of the House;

Dr. Peter Petrich, AMA Delegate;

Dr. Thomas Tyrrell, Alternate AMA Delegate;

Dr. Vincent Santare, ISMA Past President;

Dr. Wm. Fitzpatrick, District Blue Shield Representative;

Dr. Thomas Gehring, Lake County Med. Soc. Pres;

Dr. Lee Trachtenberg, President, Calumet area foundation for Med. care;

Mr. Don Foy, ISMA Executive Director;

Dr. Howard Grindstaff, ISMA Field Representative;

Mrs. Rosanna Iler, ISMA Membership Coordinator;

Mr. Herb Dixon, Vice-Pres., Blue Shield;

Mr. Mark Miles, IMPAC Representative.

Each of the guests made short but pertinent comments and answered questions.

Dr. Brown then declared the District elections in order. The following were elected to office:

President, Dr. Lee Trachtenberg;

Secretary, Dr. Barron Palmer;

District Representative to Indiana Blue Shield, Dr. Wm. Fitzpatrick.

The meeting then adjourned and reconvened at 7 p.m. for dinner.

Prior to dinner, Dr. Eli Goodman announced the

death of former ISMA Executive Secretary, James Waggener, who served in that office from 1949 to 1975. A moment of silence was observed in memory of Mr. Waggener.

During dinner, a Panasonic TV set was donated by Mr. Don Laser of Laser Pharmaceuticals Company, and it was later presented to Dr. Joseph Kopcha. Golf prizes were awarded as follows:

Closest to the pin on the 17th hole, Mrs. Mary Lou Evans;

Ladies Trophy, Mrs. Paul Alvarez;

Low net trophy, Dr. Ora Marks;

Low gross trophy, Dr. E. J. DeFrazia.

Following dinner, Dr. Brown introduced Mr. Lee Corso, head football coach of Indiana University, who delivered a rousing and hilarious talk regarding his experiences as coach at I.U. and discussed the philosophies he considers important in addition to simply winning games.

A ladies program in the afternoon featured Alexandria East, a TV personality whose subject was "Dreams—the Magic Mirror of Your Mind."

Because of my activities as Chairman of the Board of Trustees of ISMA, I haven't been able to attend as many of the LCMS meetings as I would like, but under the expert guidance of Executive Secretary John Twyman, President Dr. Thomas Gehring has been doing an excellent job. In Porter County, Dr. James Brown has been playing the dual role of PCMS President, and also President of the Tenth District and doing a very commendable job. At the last executive committee meeting, the Porter County Medical Society Charitable Trust was renamed The J. William McBride Charitable Trust in memory of Dr. McBride, one of the original Trustees, who died recently at the age of 40 years.

The Calumet Area Foundation for Medical Care has grown under the presidency of Dr. Lee Trachtenberg with the assistance of Mr. Charles Shoemaker, Executive Director, and his staff. CAPRO (Area I-PSRO) has a membership of 495 physicians in the three-county area of LaPorte, Lake, and Porter. This represents 56% of eligible physicians in this area. Dr. Frank Sturdevant, Valparaiso, is president of CAPRO and Dr. Vincent Santare is Chairman of the Board of Directors. The Executive Director duties are shared by Mr. Shoemaker with Mr. John Ling.

Again, I would like to thank all the ISMA officers and staff, and AMA Trustee, Dr. Lowell Steen, for their participation in the Annual Meeting.

MARTIN J. O'NEILL, M.D.
Trustee

Report of Trustees

Eleventh Trustee District

ACTION: Filed.

The Eleventh District Medical Society will meet Wednesday, Sept. 20, 1978. The meeting will be held at the Rolling Green Golf and Supper Club in Peru. Miami County will be the host society. They are working very hard on the program in an effort to revitalize our district meeting. Digger Phelps will be the after-dinner speaker. In addition to the business meeting, the program includes golf, tennis and an extensive program for the ladies.

Last September's meeting was hosted by the Wabash County Society at the Peru Country Club. Among the guests at the meeting were Dr. Eli Goodman, Dr. John Beeler, Dr. Vincent Santare, Dr. Marin J. O'Neill, Mr. Donald Foy and Mr. Howard Grindstaff.

The business meeting was conducted by Dr. William Dannacher, district president. Dr. Amando Baluyut was elected president of the district society and Dr. Fred Poehler was reelected secretary. Dr. Herbert Khalouf was elected alternate trustee. The members of the society expresser their desire that the secretary of the district society should fill the alternate trustee position should it become vacant.

The Eleventh District is proud that our trustee, Dr. James Harshman, has become president-elect of ISMA. Dr. Khalouf has been filling the remaining term as trustee and Dr. Poehler has been filling the office of alternate trustee.

I wish to thank the members of the Eleventh District for the privilege of representing our district on the ISMA Board of Trustees.

HERBERT C. KHALOUF, M.D.
Trustee

Twelfth Trustee District

ACTION: Filed.

The Twelfth District officers met three times this year and will meet at least once more. Business includes Twelfth District problems, planning the Annual District Meeting (held Thursday, Sept. 7, 1978, at the Imperial House Motel, Fort Wayne) and planning for the annual ISMA meeting. Several resolutions for the ISMA meeting are under consideration.

One of my trustee duties this year has been serving on the Blue Shield Liaison Committee of the ISMA. Here I have observed the physician representation on the Blue Shield Board come under the attack of both our state and federal governments, who are convinced this representation is in restraint of trade. They also are convinced that physicians serving on Blue Shield Board of Directors encourage ever-increasing payments to physicians.

I wonder. It seems to me that the Blue Shield, with its physician directors, has been extremely competitive toward other insurance companies; insureds have benefitted from this competition! Giving this observation still another twist, perhaps other insurance companies would benefit (and their customers) with physician directors! Relations between Blue Shield and ISMA have been strained over various issues in the past, but—at least at the present—both boards wish to keep the physician representation.

I personally hope this representation can be maintained in a high level of cordiality; an adversary relationship—whether forced by governmental actions or caused by disagreements—would be time-consuming, costly, and tragic to both organizations.

Another duty (and privilege) this year has been the chairmanship of the Negotiations Committee; please read its report elsewhere in this section.

Of course, the most important duty and honored privilege (now for four years) has been representing you, the Twelfth District physicians at the ISMA Board of Trustees.

At the September 1978 meeting, the following officers were elected:

President: Michael O. Mellinger, M.D., LaGrange;
Vice-President: Linus J. Minick, M.D., Churubusco;
Secretary-Treasurer: Robert H. Musselman, M.D., Fort Wayne.

The 1979 district meeting will be held Sept. 13.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District

ACTION: Filed.

The Thirteenth District Medical Society annual meeting will be held at South Bend's new Century Center Complex Sept. 13, 1978. Dr. David Spalding, President, has an exciting program scheduled; a seminar on negotiations will be followed by a business meeting, dinner and entertainment. Election for the very important position of District Representative to the Blue Shield board will occur. Dr. Francis Kubick has ably fulfilled two terms. A difficult job well done!

The previous annual meeting was not reported in the Trustees official report due to a change in the format, but it was a great success. Dr. Elmer Billings and retiring super-trustee, Dr. Beach Gattman, put on quite a show at Elcona Country Club. The business meeting featured the usual row of distinguished guests including AMA trustee, Dr. Lowell H. Steen, and ISMA presidents, Dr. Ken Olson (1960), Dr. Vincent Santare (1976), Dr. John Beeler (1977), Dr. Eli Goodman (1978) and president-elect Dr. James Harshman. Mr. Don Foy, executive director of ISMA, and many of his staff were present. Dr. David Spalding was elected presi-

Reports of Trustees

dent, Dr. William Stafk, president-elect, and Dr. Michael Quinn, secretary-treasurer. Dr. Donald Chamberlain was elected trustee to replace Dr. Gattman, who had completed the maximum allotted two terms. Dr. Gattman's distinguished service and representation for our district for the past 12 years was appreciated and recognized by a plaque given by our members. Dr. John Luce was elected Alternate Trustee to a two-year partial term originally held by Dr. Chamberlain.

Many issues were discussed, including the impact of government regulations on our practices. The district voted to reevaluate the alignment of the medical districts so that they would better conform to HSA and PSRO areas. The medical profession would thus be in

a position to monitor and respond to the many issues developed by these agencies. This suggestion is presently being considered by the ISMA.

As your new Trustee, I would like to thank the members for permitting me this honored position. In order to fulfill my responsibilities as Trustee, I need to know and understand your desires and wishes so that you may be adequately represented on a State level. Please feel free to call upon John Luce or myself regarding any problems or questions you may have in your practice. We will do our best to serve you.

DONALD S. CHAMBERLAIN, M.D.
Trustee

Reports of Committees

CONTINUED FROM PAGE 1207

- E. Continue to develop a computer center to assist in membership activities, political activities, and to become the data processor for licensing and governmental activities as appropriate to assume a major role in data collection, storage, and distribution in the best interest of organized medicine.
- F. Improve the annual convention and district medical society meetings.
- G. Continue to define roles of staff to insure their greater effectiveness and more efficient use of staff resources in being of service to the membership.
- H. Define responsibilities of committees and commissions, Board of Trustees, Executive Committee and Officers of the Association.

- I. Develop adequate law reference material.

V. It is a goal of ISMA to assist its members in improving their scientific and medical education.

- A. Expand and improve CME opportunities at ISMA meetings.
- B. Facilitate physicians' exposure to continuing medical education.
- C. Provide assistance to physicians with the management aspects of their practice.

VI. It is a goal of ISMA to represent the profession in its efforts to assist society in obtaining accessibility to quality medical care.

VII. It is a goal of ISMA to maintain communication with third party intermediaries.

Resolutions

Resolution No. 78-1

Introduced by: Subcommittee on Aging

Subject: ISMA SPECIALTY SECTION OF MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES

Action: Adopted.

Whereas, Geriatric medicine has become an increasing factor in the care of patients; and

Whereas, Extended care and long-term health care facilities have become an important factor in the delivery of health care; and

Whereas, Medical direction of these facilities involve problems peculiar to their proper function; and

Whereas, The medical direction is the province of physicians who serve as medical directors of these facilities; now, therefore be it

Resolved, That the ISMA establish a Section of Medical Directors and Staff Physicians of Nursing Facilities whose purpose will be:

1. To organize and implement guidelines for pertinent medical care;
2. To disseminate this information throughout the Section;
3. To reduce the record-keeping to workable standards;
4. To keep the rules and regulations within practicable standards of uniformity; and
5. To acquaint the Medical Directors with new procedures that improve the patient care.

Resolution No. 78-2

Introduced by: Gregory N. Larkin, M.D.

Subject: BLOOD PRESSURE MEASUREMENT AS STANDARD PROCEDURE

Action: Not adopted.

Whereas, High blood pressure is a national and state-wide foremost health problem with one in every six adults estimated to have the disease; and

Whereas, High blood pressure has been described as a "silent killer" responsible as a major risk factor in many of the 850,000 deaths annually caused by heart attack and stroke; and

Whereas, High blood pressure can be detected by a simple, inexpensive and painless test and, in most cases, can be controlled with medication; now, therefore be it

Resolved, That:

"Blood pressure measurement should be a standard procedure for any routine office visit."

Resolution No. 78-3

Introduced by: Howard County Medical Society

Subject: FUNDS FOR BOARD OF MEDICAL LICENSURE

Action: Adopted substitute resolution.

Whereas, The Indiana Board of Medical Registration and Examination has found it difficult to investigate and prosecute instances of illegal medical practice and immoral conduct of medical practitioners due to a lack of funds; and

Whereas, Fees collected by the Board for annual registration of physicians are put into the general fund of the State of Indiana instead of a dedicated fund which could be used by the Board to fund its proper operation; now, therefore be it

Resolved, That the ISMA House of Delegates agrees that available funds for the Board of Medical Registration be increased and that these funds be used only by the Board of Medical Registration and Examination for its proper operation such as improved and increased investigation and specialized legal counsel.

Resolution No. 78-4

Introduced by: Vigo County Medical Society

Subject: FREE CHOICE OF PHYSICIAN

Action: Not adopted.

Whereas, The medical profession in the State of Indiana has always been for the free choice of physician by the patient; and

Whereas, The Workmen's Compensation Law of the State of Indiana takes this choice of physician away from the patient and gives it to the employer or his compensation insurance carrier; and

Whereas, Senate Bill 183 of the 1978 State Legislature would have returned this choice to the patient if it had passed, now, therefore be it

Resolved, That the Indiana State Medical Association support the free choice of physician by the patient and actively support such a bill as Senate Bill 183 if one is introduced in the 1979 Legislature.

Resolution No. 78-5

Introduced by: Clark County Medical Society

Subject: OPPOSITION TO ISMA OFFICERS SERVING ON PSRO BOARD

Action: Not adopted.

Resolutions

Whereas, The Indiana State Medical Association, through our House of Delegates, has repeatedly voiced our philosophical objection to PSRO; and

Whereas, At present many officers of ISMA currently serve on the boards of PSRO; and

Whereas, Those who tout PSRO are using this fact to their advantage; and

Whereas, The objectives of PSRO and the objectives of ISMA are diametrically opposite, thereby causing a conflict of interest; now, therefore be it

Resolved, That this House of Delegates recommends that no officer of the Indiana State Medical Association serve in any official capacity on any board of any PSRO, and that the Indiana State Medical Association reaffirm their position of opposition so that any M.D. serving on a PSRO board does so as an individual and should resign his office in ISMA.

Resolution No. 78-6

Introduced by: Commission on Medical Services

Subject: ISMA SPOKESPERSON

Action: Referred to Executive Committee.

Whereas, There are an ever increasing number of daytime governmental meetings where professional expertise is needed when health matters are discussed; and

Whereas, Without such professional input good medical decisions cannot be made; now, therefore be it

Resolved, That ISMA solicit six ISMA members who have a thorough understanding of the health care delivery system and ISMA policies, are good communicators and listeners, and are either experienced in or interested in becoming knowledgeable in negotiations; and be it further

Resolved, That those physicians selected be directly accountable and responsible to the Board of Trustees; and be it further

Resolved, That these physicians attend designated meetings (day or night) when professional expertise is needed; and be it further

Resolved, That these physicians work closely with the Director of Health Services Planning is staying informed on all government decisions and documents concerning health, developing comments and/or reports on key issues; and be it further

Resolved, That these physicians maintain close liaison with physicians serving on the HSA boards, subarea councils and committees; and be it further

Resolved, That these physicians submit written or oral reports to the Board of Trustees regarding all governmental meetings attended.

FISCAL NOTE: \$100,000

Resolution No. 78-7

Introduced by: Commission on Medical Education

Subject: MEDICAL STUDENT COMPONENT SOCIETY

Action: Adopted.

Whereas, The Bylaws of the Indiana State Medical Association, as adopted at the annual meeting in 1977, call for representation of the entire student body of Indiana University School of Medicine rather than through AMSA; and

Whereas, The Bylaws call for a student delegate and alternate, but without a system established for their election; now, therefore be it

Resolved, That Chapter 1, Section 3, Paragraph I of the Bylaws be amended by adding a new paragraph as follows:

"The Student Council of the Indiana University School of Medicine shall elect a student delegate and alternate delegate from nominees presented to them from each class. All resolutions introduced in the name of the student body must be presented through the Student Council functioning as the executive body of the student members—in effect, a student component society."

Be it further

Resolved, That the election of delegates and alternate delegates should be made with consideration of maximum continuity of student representation.

Resolution No. 78-8

Introduced by: Marion County Medical Society

Subject: UNIFORM HEALTH INSURANCE CLAIM FORM

Action: Adopted as amended and referred to Board of Trustees for implementation.

Whereas, A Uniform Health Insurance Claim Form has been developed to maximize the efficiency of physicians' filing of medical care claims to benefit the patient through timely adjudication of claims; and

Whereas, Blue Cross and Blue Shield of Indiana, as fiscal agent for Medicaid in Indiana, declines to accept the Uniform Health Insurance Claim Form, thereby causing delay in reimbursement in behalf of patients; and

Whereas, The resultant delays diminish the ability of physicians to accept Medicaid patients; and

Whereas, Similar inconsistencies in required filing procedures work to the disadvantage of other third-party paid patients; now, therefore be it

Resolved, That the Indiana State Medical Association adopt the Uniform Health Insurance Claim Form

Resolutions

as developed or as it may be amended by the American Medical Association, and encourage its acceptance and use by Medicare, Medicaid, CHAMPUS, and other third-party government intermediaries in Indiana; and be it further

Resolved, That the Indiana state insurance commissioner be appraised of this action and urged to use his good offices to implement this resolution so as to mandate the acceptance of this uniform insurance form by all health insurance companies in Indiana.

Resolution No. 78-9

Introduced by: Marion County Medical Society

Subject: ADMISSION TO AMA PROGRAMS AND SEMINARS

Action: Adopted and referred to Indiana Delegation to the AMA.

Whereas, The American Medical Association develops educational programs and seminars for the benefit of physicians and organizations within the Federation; and

Whereas, Attendance at such programs and seminars by non-physicians, not affiliated with the Federation, is not subject to approval of component and state associations; and

Whereas, The success of AMA programs and seminars may in fact work to the disadvantage of the component and state associations and their members; now, therefore be it

Resolved, That the American Medical Association Board of Trustees and appropriate Council study the potential negative effects of admission of non-physician, non-Federation affiliated personnel to non-medical AMA programs and seminars without approval of the potentially affected component and/or state association.

Resolution No. 78-10

Introduced by: Marion County Medical Society

Subject: SPEAKER AND VICE SPEAKER OF THE HOUSE IN AMA DELEGATION

Action: Adopted as amended.

Whereas, The House of Delegates is the crucible in which Indiana State Medical Association policies are forged; and

Whereas, The ISMA Delegation to the American Medical Association has the obligation to reflect the attitude of Indiana physicians; and

Whereas, The Speaker and Vice Speaker of this House of Delegates, as its elected Chairmen, can and

should augment the breadth and depth of the ISMA Delegation before the House of Delegates of the American Medical Association; now, therefore be it

Resolved, That the Speaker and Vice Speaker of the ISMA House of Delegates accompany and support the ISMA Delegation to the AMA and be reimbursed for travel accordingly.

FISCAL NOTE: ISMA Current Policy

The expenses incurred by the president, president-elect and the chairman of the Board of Trustees of the Indiana State Medical Association are the responsibility of the Association.

Delegates and alternate delegates to the AMA are reimbursed \$750 for each meeting attended (\$1,500 annually).

Resolution No. 78-11

Introduced by: Marion County Medical Society

Subject: SECOND OPINIONS

Action: Adopted and referred to the Board of Trustees for implementation.

Whereas, The advisability of any specific therapy, medical or surgical, is a matter of professional opinion; and

Whereas, Historically physicians have recognized the value of consultation; and

Whereas, Third-party payors, including state and federal governments, are beginning to seek mandatory second opinions for all elective surgical procedures; now, therefore be it

Resolved, That the Indiana State Medical Association supports the right of a patient or physician to seek consultation freely with any consultant of his or her choice and opposes the concept of mandatory consultation required by third-party payors; and be it further

Resolved, That the Indiana State Medical Association supports the concept of qualified and necessary consultants and opposes the concept of panels of consultants, open or closed; and be it further

Resolved, That the Indiana State Medical Association supports the concept that when second or more opinions are mandated by any party, this party is responsible for the consultant fee and related tests and the choice of consultant is the responsibility of the patient and/or the attending physician; and be it further

Resolved, That the Indiana State Medical Association vigorously opposes the misconception that a second opinion is more valid than the first.

Resolution No. 78-12

Introduced by: Marion County Medical Society

Subject: MEMBERSHIP RECRUITMENT—

Resolutions

DUES REDUCTION

Action: Adopted as amended with referral to the Commission on Constitution and Bylaws.

Whereas, Research commissioned by the American Medical Association has disclosed advantages to membership recruitment through reduction of dues in the early years of practice; and

Whereas, The American Medical Association has acted to reduce by one-half the dues for AMA membership for physicians in their first year of practice following formal training; and

Whereas, The results of the research conducted by the American Medical Association should be equally applicable to the membership recruitment activities of the Indiana State Medical Association; now, therefore be it

Resolved, That the Indiana State Medical Association dues for active members in their first year of practice following formal training shall be one-half the amount as may be established by the House of Delegates, and be it further

Resolved, That county societies be encouraged to follow the same policy.

TO: HOUSE OF DELEGATES

FROM: CHAIRMAN OF THE EXECUTIVE COMMITTEE

RE: STUDENT LOAN FUND

The Board of Trustees voted in 1957 to recommend to the House of Delegates that dues be increased by the sum of \$10 per member, specifically for the American Medical Education Foundation (AMA-ERF). In 1963, a resolution was passed which provided for a realignment of the dues structure. Essentially it provided that half of that amount, or \$5, be allocated to fund the Student Loan Program.

The Student Loan Fund is a separate charitable trust established in 1955 for the purpose of making loans to medical students. Under the Student Loan program agreement, there is a provision that requires the Association to maintain in the account a sum of not less than 8% of the aggregate of outstanding loans, including interest or a constant maximum of \$40,000. Since this maximum has long since been achieved, the \$5 annual dues allocation for the Student Loan Program reverts to the General Fund, along with accumulated interest.

Under the terms of an agreement with the Indiana National Bank, Indianapolis, the bank makes loans to students enrolled and in satisfactory standing at the Indiana University Medical School at the rate of \$12.50 for each dollar placed in a capital reserve at the bank.

The bank held \$20,810 in the capital reserve on Sept. 30, 1977 (represented by certificates of deposit), thereby producing an available loan balance approximating \$260,000. There are no outstanding loans at present.

The Executive Committee, in conjunction with the Student Loan Committee, reviews the student loan situation annually for the purpose of authorizing further general fund appropriations to the loan fund as additional funds are needed to guarantee loans under the agreement with the bank.

Earlier this year, the Executive Committee reviewed the status of the Student Loan Program and found that the overall demand for student loans has declined during the past several years primarily due to the adequacy and availability of federal funds. Also, other loan guarantee programs from such sources as the AMA-ERF and the Robert Wood Johnson Foundation are readily available. In actual fact, there appears to be little if any demand for continuation of ISMA's loan program.

Accordingly, the Executive Committee recommends to the House of Delegates that the Student Loan Program be terminated and that the amount remaining in the Student Loan Fund revert to the General Fund. (See Resolution 78-13 below)

Resolution No. 78-13

Introduced by: ISMA Executive Committee

Subject: STUDENT LOAN PROGRAM

Action: Adopted substitute resolution.

Resolved, That the Board of Trustees review the relationships of the ISMA Student Loan Program to other financial aid programs available to medical students and consider the possibilities for making the ISMA Student Loan Program a practical alternative or supplement for needy medical students who are residents of Indiana; and be it further

Resolved, That the Board of Trustees maintain the present charitable trust inviolate and with appropriate fiduciary safeguards until this House of Delegates makes a further determination of policy concerning the Student Loan Program.

Resolution No. 78-14

Introduced by: Vanderburgh County Medical Society

Subject: CONTINUOUS CARE IN HEALTH CARE FACILITIES

Action: Referred to the Commission on Medical Services for further study and recommendations to the 1979 House of Delegates.

Resolutions

Whereas, A physician is the appropriate means of entry into the health care system; and

Whereas, He is best able to evaluate the patient's total health needs, to provide basic personal medical care, and when indicated to refer the patient to appropriate sources of care, while preserving continuity of care; and

Whereas, He assumes responsibility for the patient's comprehensive and continuous health care, acting as a coordinator of the patient's health services when needed; and

Whereas, A patient, who in good faith entrusts his health care to a medical facility which functions for only limited periods each day, forcing the patient to seek alternative sources for care when urgently needed outside regular hours, is receiving less than quality medical care; now, therefore be it

Resolved, That any health care facility which does not provide for continuous care available 24 hours a day, seven days a week, should not be considered entitled to licensure by any governmental agency or reimbursement by third-party agencies; and be it further

Resolved, That the Indiana State Medical Association seek to influence legislation and governmental regulations in order to ensure the availability of round-the-clock medical care by such health care facilities.

Resolution No. 78-15

Introduced by: Edward Langston, M.D.

Subject: FORMATION OF A RESIDENT PHYSICIAN SECTION

Action: Not adopted.

Whereas, The AMA formed a Resident Intern Business Section in 1970 and then subsequently formed a Resident Physician Section by action of the House of Delegates in 1975 and the Resident Physician Section became fully active commencing at the June, 1977, AMA meeting; and

Whereas, Resident Physician membership in the AMA now stands at approximately 14,000; and

Whereas, The Indiana State Medical Association has sponsored a delegate to the House of Delegates of the RPS of the AMA at the December, 1977, interim meeting in Chicago and the annual meeting in June, 1978, at St. Louis, as an expression of its interest and solicitation of resident input within the state of Indiana; now, therefore be it

Resolved, That the Indiana State Medical Association form a Resident Physician Society to participate as a component society within its government auspices; and be it further

Resolved, That the RPS have the appropriate number of delegates authorized to participate with full voting rights in the Indiana State Medical Association House of Delegates as commensurate with its membership in accordance with the rules for representation as determined presently for individual county societies.

Resolution No. 78-16

Introduced by: Donald S. Chamberlain, M.D.

Subject: COMMUNICATING INFORMATION ON ORGANIZED MEDICINE TO STUDENTS, INTERNS AND RESIDENTS

Action: Adopted and referred to the Board of Trustees for implementation.

Whereas, It is in the best interest of all physicians and their patients that medical students, interns and residents be totally knowledgeable in the socioeconomic, legislative, and political aspects of medicine; now, therefore be it

Resolved, That an ad hoc committee of the Indiana State Medical Association composed of officers and staff of ISMA and delegates to the AMA be developed and prepare an educational program for presentation to medical students, interns and residents; and be it further

Resolved, That this program be presented to each of the teaching centers throughout the state upon request by the appropriate medical society, and that such presentation be conducted in a regular medical society meeting so that all in attendance may benefit from such information including costs and benefits of membership in organized medicine; and be it further

Resolved, That this committee also encourage participation of all physicians in educational programs, especially at the local level designed to inform them of organized medicine's activities, goals, accomplishments and future plans.

Resolution No. 78-17

Introduced by: LaPorte County Medical Society, Inc.

Subject: COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS (CCMHCs)

Action: Adopted as amended.

Whereas, The Indiana Department of Mental Health and the Indiana Legislature have determined the need for 32 Comprehensive Community Mental Health Centers in Indiana to deliver care to the emotionally disturbed and to persons involved with substance abuse; and

Whereas, A reliance on this community system for delivery of mental health services has been determined

Resolutions

to be able to care for most emotionally disturbed Indiana citizens with a corresponding decrease in state hospital services; and

Whereas, Many millions of dollars have already gone into this system of care, and many more millions of dollars are anticipated to go into this system; and

Whereas, Coordination of these community mental health services with existing hospitals, physicians, and other health care providers has been a problems; and

Whereas Comprehensive community mental health services operate under House Enrolled Act No. 1698 (the Medical Practice Act) whereby mental health professionals not licensed for independent practice must operate under the direct supervision of a physician; and

Whereas, Medical direction of these services has been promised but not always provided, to the detriment of patient care; now, therefore be it

Resolved, That all Comprehensive Community Mental Health Centers establish a medical advisory committee to their Board consisting of representatives from area hospital medical staffs, private and CCMHC psychiatrists, county medical society (ies), and state hospital psychiatrists to coordinate private and public delivery of mental health services, and be it further

Resolved, That the Indiana Department of Mental Health continue to cooperate with the Medical Licensing Board of Indiana in assuring proper credentials and supervision of Comprehensive Community Mental Health Center staffs providing psychotherapy, psychological testing, and other mental health services to community agencies and to the public, and be it further

Resolved, That the ISMA supports mental health service delivery plans which require that such patient care be the responsibility of a psychiatrist, including initial and periodic review and approval of patient evaluations, development and implementation of treatment plans, the determination for the level of care required, and the determination for the need for medication; and be it further

Resolved, That the ISMA recommend change of the recent revision of the Joint Commission on Accreditation programs for psychiatric facilities to reflect that above position.

Resolution No. 78-18

Introduced by: Lake County Medical Society
Subject: BLUE SHIELD BOARD NOMINATIONS
Action: Referred to the Commission on Constitution and Bylaws for recommendations to the 1979 House of Delegates.

Whereas, Six nominations to the Board of Directors

of Indiana Blue Shield are made as at-large selections by ISMA, being named in addition to the single nominations made by each District Medical Society, and

Whereas, The House of Delegates of the Indiana State Medical Association is the representative body of the membership at-large, while the Board of Trustees is composed of representatives also from the District Medical Societies; now, therefore be it

Resolved, That as future vacancies occur on the Blue Shield Board among the at-large representatives, these nominations be chosen by the House of Delegates in the same manner that other State Association officers are selected.

Resolution No. 78-19

Introduced by: Lake County Medical Society
Subject: PUBLICATION OF MINUTES
Action: Not adopted.

Whereas, Communication with the rank and file membership of the Indiana State Medical Association is difficult, but vital, to the good health of the Association; and

Whereas, THE JOURNAL of ISMA is the major publication sent to, and read by the membership; now, thereforer be it

Resolved, That the minutes of the meetings of the Board of Trustees and Executive Committee be printed and distributed by THE JOURNAL or some other official ISMA publication, so that all members will be fully informed of the business of the Association being conducted at these meetings.

FISCAL NOTE: Cost of printing in THE JOURNAL

\$450 per printing of Board Meeting Minutes; \$250 per printing of Executive Committee Minutes.

Resolution No. 78-20

Introduced by: Executive Committee, ISMA
Subject: COST CONTAINMENT
Action: Adopted as amended.

Whereas, Increases in the cost of medical care are real and continuing, causing concern by individuals, families, business, government and physicians; and

Whereas, Much of the increase in cost is caused by new technology and treatment methods which result in better care, prolonged life or a better quality of life; and

Whereas, Other important factors causing the increases in costs are government regulations, higher labor, energy and malpractice costs and general inflation; and

Resolutions

Whereas, The American Medical Association, American Hospital Association and Federation of American Hospitals late in 1977 created the Voluntary Effort aimed at moderating increases in hospital charges which have already begun to moderate; and

Whereas, Tom E. Nesbitt, M.D., President of the American Medical Association, called on physicians in his inaugural address to use similar restraint in their fee increases; now, therefore be it

Resolved, That the Indiana State Medical Association endorses the call by AMA President Tom E. Nesbitt, M.D., and urges physicians to participate in the voluntary effort.

Resolution No. 78-21

Introduced by: Clark County Medical Society
Subject: HEALTH SCREENING PROGRAMS
Action: Adopted as amended.

Whereas, There is an increasing number of screening programs being conducted by various health groups and associations throughout Indiana; and

Whereas, The Clark County Medical Society is quite concerned about non-medical groups performing medical procedures without any physician supervision; now, therefore be it

Resolved, That any ancillary screening group be encouraged to submit a plan to the local medical society where the program is going to take place for the society's approval and assistance to insure there is no overlap of services and general waste of funds at the local, state, or federal level.

Resolution No. 78-22

Introduced by: Tippecanoe County Medical Society
Subject: COOPERATION WITH PSRO
Action: Adopted substitute resolution.

Resolved, That efforts to try to preserve confidentiality be vigorously encouraged and pursued; and be it further

Resolved, That it is the consensus of this House that the necessary activities to accomplish this important objective do not constitute endorsement, by ISMA, of any governmental or third-party program.

Resolution No. 78-23

Distributed by: ISMA Board of Trustees
Subject: NOMINATION FOR BLUE SHIELD BOARD
ACTION: Adopted as amended.

Resolved, That the following amendment be made in substitution for Chapter XIV, Section 9, entitled "Election to Blue Shield."

"Each district medical society may recommend nominees from its membership (a physician subscriber to Mutual Medical Insurance, Inc.) to serve on the Board of Directors of MMI. The physician recommended will be submitted for nomination at the annual meeting of Mutual Medical Insurance, Inc. In addition ISMA Board of Trustees may recommend additional nominees," and be it further

Resolved, That in place of the present title and the title recommended by the Board of Trustees that the Commission on Constitution and Bylaws recommend that the title read:

"Section 9—Recommendation of Nominees to the Board of Directors of Mutual Medical Insurance, Inc."

Resolution No. 78-24

Introduced by: Vanderburgh County Medical Society
Subject: PENNSYLVANIA COURT ACTION
ACTION: Adopted

Whereas, Section 3 of the "Principles of Medical Ethics" of the American Medical Association states that "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle"; and

Whereas, Chiropractic has been deemed to lack scientific basis; and

Whereas, The rendering of clinical laboratory reports, and the rendering of radiologic reports to another professional constitutes an important part of the practice of medicine, be it therefore

Resolved, That the Indiana State Medical Association opposes settlement by the American Medical Association's Board of Trustees of the antitrust suit against AMA brought by plaintiffs in the Federal District Court of Eastern Pennsylvania.

Resolutions, Adjournment

Resolution No. 78-25

Introduced by: John W. Beeler, M.D.
Subject: AFFIRMATION OF PRESENT
AMA CODE OF ETHICS
ACTION: Adopted as amended.

Resolved, That ISMA request the House of Delegates of the American Medical Association considering the present and proposed Principles of Medical Ethics of the American Medical Association and the interpretations of the Principles as published in *Judicial Council Opinions and Reports*, 1977, to:

- 1) Retain the present language of the Principles, Section 3 advising that a physician should not voluntarily associate professionally with anyone who practices a method of healing not founded on a scientific basis;
- 2) Retain the language in the Principles, Section 5, that states that a physician, "should not solicit patients"; and that
- 3) The Judicial Council reconsider the implications of the interpretation of Section 3.70 which requires a physician who provides diagnostic services to a patient recommended to him by a licensed limited practitioner, to inform the patient if the results of the examination indicate the possible need for surgical or drug treatment.

Presidential Resolution

ACTION: Adopted by acclamation.

Whereas, Eli Goodman, M.D., 1977-78 president of the Indiana State Medical Association, accepted the Association's highest office during a period of such major problems as the threat of national health insurance; and

Whereas, Dr. Goodman, with purposeful insight, outlined in his inaugural address certain goals he intended to establish for the Association, such as visiting state and federal legislators to seek their personal commitment to medicine's endeavor to win public support; and

Whereas, He helped mobilize, and became president of, the Indiana Task Force on Health Care Costs in an

effort to voluntarily slow the rate of increase of such costs; and

Whereas, Dr. Goodman set several other goals that included increasing Association membership, improving lobbying efforts, and promoting in-house computer capabilities; and

Whereas, He decisively and diligently dedicated his and the Association's energies and activities to insure that these and other goals would meet with success; and

Whereas, His efforts as president have demanded innumerable hours of extra effort at great sacrifice to both him and his family; now, therefore be it

Resolved, That this House of Delegates, on behalf of the entire membership, express its sincere gratitude and appreciation to Dr. Goodman for his untiring efforts and outstanding leadership as president of the Indiana State Medical Association.

Resolution to Staff and Others

ACTION: Adopted by acclamation.

Whereas, A successful 129th Annual Convention of the Indiana State Medical Association is drawing to a close; and

Whereas, Executive, logistical and clerical assistance and direction from the ISMA staff has complemented the efforts of the Commission on Convention Arrangements; and

Whereas, During the long planning phase preceding the Convention, the staff of the Marriott Inn and Kentuckiana Convention and Sports Center exhibited an excellent spirit of cooperation; and

Whereas, The Convention's educational program has been financially assisted by various contributors and by technical exhibitors; now, therefore be it

Resolved, That this House of Delegates, on behalf of the entire membership, express its sincere gratitude and appreciation to the ISMA staff, the Commission on Convention Arrangements, the staff of the Marriott Inn and Kentuckiana Convention and Sports Center, and to all those who financially contributed to the successful educational program during the 1978 Annual Convention.

Future Annual Conventions

1979 (October 13-17)	— Indianapolis
1980 (October 11-15)	— Indianapolis
1981 (October 24-28)	— Indianapolis
1982 (October 16-20)	— Indianapolis
1983 (Dates to be set by Board of Trustees)	— Evansville

Adjournment

Constitution and Bylaws

Constitution

ARTICLE I—TITLE AND DEFINITION

The name of this organization is the Indiana State Medical Association. It is the federacy of Indiana county medical societies.

ARTICLE II—PURPOSES

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the state of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly relations among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care and public health so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies are those county and district medical societies contained within the state of Indiana, and who hold charters from this Association.

ARTICLE IV—MEMBERS

The Indiana State Medical Association is composed of individual members of county medical societies and others as shall be provided in the Bylaws.

ARTICLE V—HOUSE OF DELEGATES

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in the Constitution and Bylaws and shall elect the general officers, except trustees, as otherwise provided in the Bylaws.

ARTICLE VI—OFFICERS

The general officers of the Association shall be

a president, president-elect, immediate past president, treasurer, assistant treasurer, speaker, vice speaker, and the trustees. Their qualifications and terms of office shall be provided in the Bylaws.

ARTICLE VII—TRUSTEES

The Board of Trustees is composed of trustees and alternate trustees elected by the component district medical societies, and the president, the president-elect, treasurer, immediate past president, the assistant treasurer, with power to vote only in the absence of the treasurer, and the speaker and vice speaker without power to vote and the executive director without power to vote. The alternate trustees have power to vote only in the absence of the trustee.

The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by the law governing directors of corporations or as may be prescribed in the bylaws.

ARTICLE VIII—THE CONVENTION

The House of Delegates and the general scientific program shall be convened annually and at such other times as deemed necessary or as provided in the Bylaws, in cities recommended by the Board of Trustees and approved by the House of Delegates.

ARTICLE IX—FUNDS, DUES AND ASSESSMENTS

Funds may be raised by annual dues or by assessment of the active members on recommendation of the Board of Trustees and after approval by the House of Delegates, or in any other manner approved by the Board of Trustees as provided in the bylaws.

ARTICLE X—AMENDMENTS

The House of Delegates may amend this Constitution at any convention provided the proposed amendment shall have been introduced at the preceding annual convention and provided two-thirds of the voting members of the House of Delegates vote approval and provided that it shall have been published twice during the year in *The Journal* of the Association.

Bylaws

DIVISION ONE—MEMBERSHIP

CHAPTER I—QUALIFICATIONS, ELECTION AND RIGHTS

Section 1. Regular Member. The term “regular member” as used in these Bylaws shall include Active, Senior, Military Service Member, Veterans Administration Member, Public Health Service Member, Disabled Member, Medical Student Member, Interns and Residents, of component county medical societies who hold the degree of Doctor of Medicine or Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery unless the license has been surrendered because of retirement as required in the Medical Practice Law. As to Interns and Residents they shall be serving in training programs approved by the Association, or if a Medical Student they shall be enrolled in a medical school approved by the Association. All regular members are entitled to exercise the rights of membership in their county and state associations, including the right to vote and hold office, as determined by their respective county medical society and/or their state association.

A *regular member* who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Section 2. Special Member. The term “special member” as used in these Bylaws, unless otherwise indicated, shall mean Associate Members and Honorary Members as defined in Section 3, Chapter I of the Bylaws of the Indiana State Medical Association. Special members shall not be entitled to vote or hold office in this association.

Section 3—Members by Category

A. Active Members. The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Association.

B. Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

C. Senior Members. Senior Members shall be eligible for Senior Membership on January 1 following their 70th birthday and they shall be physicians of the State of Indiana and who have held their membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of 20 years or more, and who, upon their application, have been certified to the Executive Director as eligible for such membership by the county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other state organization or organizations, the fact of membership therein when such membership

is claimed as part compliance with the eligibility requirement of 20 years of membership.

D. Honorary Members. Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association. Such honor may be conferred by the vote of the House of Delegates.

E. Disabled Members. Disabled members shall consist of physicians of the State of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine and who continue to reside in the State of Indiana. Proof of permanent disability shall be by notification to the Executive Director of the Association by the secretary of the county medical society in which such permanently disabled physician holds membership.

All such disabled members shall receive membership cards and THE JOURNAL of the Association without charge.

F. Distinguished Members. Active members who have fulfilled the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum shall be designated as Distinguished Members.

G. Military Service Members, Veterans Administration Members and Public Health Service Members. Any physician who is actively engaged in the military service, veterans administration, or public health service shall be eligible for membership in the Association with payment of regular dues; they shall receive THE JOURNAL.

H. Inactive Membership. Regular members who decide voluntary inactivity prior to the age of 70 shall be exempt from payment of membership dues for the duration of their inactive status when recommended by the County Medical Society and approved by the Board of Trustees. The inactive member shall receive THE JOURNAL of the Indiana State Medical Association without charge.

I. Student Members. Medical students who attend an accredited medical school in Indiana.

Student members may be represented in the House of Delegates with the power to vote. They shall be entitled to send one delegate or one alternate. Student delegate and alternate are to receive THE JOURNAL of the State Association.

The Student Council of the Indiana University School of Medicine shall elect a student delegate and alternate delegate from nominees presented to them from each class. All resolutions introduced in the name of the student body must be presented through the Student Council functioning as the executive body of the student members—in effect, a student component society.

Section 4—Rights and Privileges of Members

A. Suspension or Revocation of License

No person whose license to practice medicine has been suspended or revoked or who is under sentence of suspension or expulsion from a component society, or

whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association or of a component county society, nor shall he be permitted to take part in any of their proceedings until he has been relieved of such disability. This shall not apply to the physician who has surrendered his license because of retirement under the provisions of the Medical Practice Law.

B. Attendance at Annual Convention

Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

C. Rights and Privileges by Membership Category

Rights and Privileges of Members. Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and inactive members shall have the same rights and privileges except as follows:

(a) Senior members shall not be required to pay membership dues in the State Association.

(b) If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

CHAPTER II—DUES, FUNDS AND ASSESSMENTS

Section 1—Dues

A. Income and Expenses

Funds for carrying on the activities of this Association shall be raised by the following means:

(a) Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

(b) Voluntary contributions.

(c) Revenues derived from the Association's publications.

(d) Upon recommendation of the Board of Trustees or any other manner approved by the House of Delegates.

Funds shall be appropriated by the Board of Trustees to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions recommending the appropriation of funds by the House of Delegates must be referred to the Board for recommendation before final action is taken by the House of Delegates.

B. Change in Dues Structure

The final vote on any issue calling for changes in dues or in dues structure shall be by roll call vote of the House of Delegates. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote on such an issue.

DIVISION TWO—

ANNUAL CONVENTION ACTIVITIES

CHAPTER III—CONVENTION AND MEETINGS

Section 1—Annual Convention

The Association shall hold an Annual Convention

during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Section 2—Selection of Site

The House of Delegates shall select the place five years in advance for holding the Annual Convention. The time for the convention shall be fixed by the Board, and the Board shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Any of the component member county societies wishing to invite the Indiana State Medical Association to hold its annual meeting in its locality shall submit an invitation in writing at least five years in advance to the Board of Trustees. The Board of Trustees shall make an investigation of the facilities and in turn recommend the location to the annual meetings for concurrence by the House.

Section 3—Special Meetings

Special meetings of either the Association or the House of Delegates shall be called by the President upon receipt of a petition signed by thirty delegates or one hundred members. The signed petition shall contain the names of at least ten delegates or thirty-four members from each of at least three Board districts. Upon receipt by the President of such a petition, the President shall within thirty days thereafter issue a call for such special meeting at a time and place to be fixed by the President. The President, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made.

Section 4—General Meetings

General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers.

Section 5—Appointment of Committees

The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Section 6—Scientific Papers

All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Director when read.

Section 7—Appropriations

The Board of Trustees shall appropriate from the funds of the Association such an amount as in the discretion of the Board shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money

in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER IV—SPECIALTY SECTIONS

Section 1—Official Sections

During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

- a. Surgical.
- b. Internal Medicine.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. Family Physicians.
- f. Obstetrics and Gynecology.
- g. Preventive Medicine and Public Health.
- h. Radiology.
- i. Nervous and Mental Diseases.
- j. Pathology and Forensic Medicine.
- k. Pediatrics.
- l. Directors of Medical Education.
- m. Cutaneous Medicine.
- n. College Health Physicians.
- o. Interns and Residents.
- p. Allergy.
- q. Urology.
- r. Orthopedic Surgery.
- s. Emergency Medicine.
- t. Neurological Surgery.
- u. Medical directors and staff physicians of nursing facilities.

All future sections will be formed by properly constituted resolution which shall include the signatures of a minimum of 15 members or 25% of the members, whichever is greater, who are practicing that specialty in the state of Indiana.

Section 2—Officers

The officers of each section shall be a chairman, a vice-chairman, and a secretary, and they shall preside over the meetings of the sections and shall be responsible to the Commission on Convention Arrangements for the section speakers and papers.

Section 3—Officer Elections

The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Section 4—Restriction on Meetings

No section meeting shall be allowed to conflict with a general meeting.

DIVISION THREE— BUSINESS AND LEGISLATION

CHAPTER V—HOUSE OF DELEGATES

Section 1—Composition

The House of Delegates shall be the legislative and policy-making body of the Association and shall consist of (1) Delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, and (3) the ex-presidents of the Indiana State Medical Association. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be ex officio members: The President, the President-Elect, the Executive Director, the Treasurer and Assistant Treasurer of this Association, the Speaker, the Vice Speaker and the delegates to the American Medical Association, all without

power to vote, except the Speaker and Vice-Speaker who shall vote as set forth in Chapter VI, Section 3 (F) and (G) hereafter.

Section 2—Meetings

The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the general or section meetings. It shall meet on the last day of the Annual Convention for the completion of any business previously introduced. for the election of officers for the ensuing year, and The order of business shall be arranged as a separate section of the program. Nominations for officers of the Association may be made at any meeting of the House of Delegates.

Section 3—House Admission

All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation.

Section 4—Delegate Apportionment

Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county. The student delegate shall be seated with full power to vote. In the absence of the student delegate, the alternate shall be seated with full power to vote.

The number of delegates to which each component society is entitled shall be based upon the number of members on record in the office of the Executive Director in good standing with current dues fully paid as of December 31 of the preceding year.

All sections listed in Chapter III, Section 1, of these Bylaws shall be entitled to send to the House of Delegates each year one delegate or one alternate delegate without the power to vote.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Director of this Association on or before February 1, prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credential card as a delegate or alternate, properly signed by the secretary of his county medical society, executive secretary or executive director of the larger societies, is presented to the Committee on Credentials at the time of the Annual Convention.

Section 5—Quorum

Fifty (50) delegates shall constitute a quorum.

Section 6—Responsibilities

A. Delegates to American Medical Association

The House of Delegates shall: elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

B. Organizing Districts and Sections

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Trustee District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Trustee districts shall be defined by the House of Delegates.

The House shall divide the state into Trustee districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

C. Authority to Appoint Special Committees

The House shall have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

Section 7—Resolutions and Proposals

The House of Delegates shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Proposals calling for appropriations of funds by the House of Delegates shall be accompanied by a fiscal note and shall be submitted to the Executive Committee and the Board for review, presentation and recommendation for final action of the House. No proposal calling for appropriations shall be considered if not accompanied by a fiscal note.

All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Director of the Association so that he will receive them not later than 45 days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Director more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reasons why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the By-laws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Section 8—Reference Committees and Committee on Rules and Order of Business

A. Reference Committees

Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the Speaker with the assistance of the President. The chairman of each committee shall also be appointed by the Speaker with the assistance of the President and they shall also appoint such additional House committees as the House may approve. All committees hereunder shall serve only during the convention at which they are appointed. Appointments shall be made in time for them to be published in *THE JOURNAL* and the Handbook prior to such Annual Convention.

The Speaker with the assistance of the President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of at least five members, three of whom including the chairman shall be delegate-members of the House, unless otherwise provided. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except matters as properly come before the Board, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

B. Responsibilities of Reference Committees

Four or more Reference Committees designated by numerals are hereby constituted to which all matters shall be referred, at least one of which shall be organized for the sole purpose of studying the addresses of the president; president-elect; report of the Executive Director; and chairman of the Board of Trustees. This committee shall be mandated to translate recommendations made by these officers through resolutions for presentation to the House.

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the Speaker of the House, be made (a) to as many reference committees as are necessary to cover all subjects included therein; or (b) to only one reference committee which the Speaker deems has within the scope of its reference the most important part of the matter referred.

No report of any reference committee shall be rejected on the ground that it covers something not included in the matters which such committee was created to consider.

C. Time and Place of Meetings

The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

Persons who are not members of the Indiana State Medical Association and seek to appear and present their technical or reference material to the reference committee must receive approval to appear on that specific subject from the reference committee.

Non-Indiana State Medical Association members must register as guests at the committee and be at the call of the reference committee for testimony after which they may be excused from further attendance.

D. Committee on Rules and Order of Business

The Committee on Rules and Order of Business shall be composed of the chairmen of the various Reference Committees appointed by the Speaker.

Section 9—Election of Officers

The officers of this Association with the exception of the Executive Director shall be elected by the House of Delegates as the first order of business at the final meeting of the House of Delegates, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

The officers, except the Executive Director shall be elected annually. All officers shall serve until their successors are elected and installed.

A. Method of Election

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

B. Terms

The President, President-elect, Speaker, Vice-speaker, Treasurer and Assistant Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect, Treasurer and Assistant Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

C. Oath

The officers of the Association shall be installed by taking the following oath of office to be administered by the outgoing President of the Association at the final meeting of the House of Delegates:

I, _____, solemnly swear that I shall carry out to the best of my ability, the duties of the office of the Indiana State Medical Association to which I have been elected.

I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to do the task of bringing increasingly improved medical care within the reach of every citizen.

I shall uphold the Constitution of the United States of America and of the State of Indiana, the Constitution and Bylaws of the American Medical Association and the Constitution and Bylaws of the Indiana State Medical Association at all times.

I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations, I pledge myself, so help me God.

CHAPTER VI—OFFICERS

Section 1—Composition

The officers of this Association shall be a President, a President-Elect, the Immediate Past President, an Executive Director, a Treasurer, an Assistant Treasurer, a Speaker, a Vice-Speaker, each of whom shall be a member, except the Executive Director, who need not necessarily be either a physician or a member.

Section 2—Removal, Death, Resignation, Vacancy

Any officer may be removed from office after a hearing before the Board, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Board.

In the event of the death, resignation, removal, or disability of the President, the President-Elect shall succeed to the presidency. In the event of the death, resignation, removal, or disability of both the President and the President-Elect, the Chairman of the Board shall become President Pro Tem and shall perform the duties and obligations as set forth in Section 3 of this chapter. As President Pro Tem the Chairman of the Board shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-Elect shall be elected, both of whom shall take office immediately upon their election.

The Board shall fill a vacancy in the office of Treasurer or Assistant Treasurer by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

Section 3—Duties

A. President

The President, or a member designated by him shall preside at all general meetings of the Association. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Trustees in building up the county societies and in making their work more practical and useful.

B. President-elect

The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties. Ex officio, he shall be a member of all commissions and committees.

C. Treasurer

The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Board. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the chairman of the Board. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

D. Assistant Treasurer

The Assistant Treasurer shall give bond at the expense of the Association in such amount as shall be required by the Board unless he is included in the coverage of a blanket or position bond. In case of death, or incapacity of the Treasurer, he shall succeed to all the duties and rights of the Treasurer until a new Treasurer be elected. In the absence of the Treasurer, he shall attend to the duties and rights of the Treasurer during such absence and he shall also perform such duties of the Treasurer as may be delegated and assigned to him by the Treasurer.

E. Executive Director

The Executive Director shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Board, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to nonprofessional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Board, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Board.

F. Speaker

The Speaker shall preside at all meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He may address the House of Delegates at the opening meeting of all conventions, limiting his address to matters of conduct and procedure in the House. He is entitled to vote when the vote is by ballot. In all other cases, he shall have the right to vote only in case of a tie.

He shall be elected annually from the membership of the House. Ex officio, the Speaker shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Speaker and shall be provided at the expense of the Association.

G. Vice Speaker

The Vice Speaker of the House of Delegates shall officiate at meetings in the absence of the Speaker or at the request of the Speaker. The Vice Speaker shall be elected annually from the membership of the House. Ex officio, he shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Vice Speaker and shall be provided at the expense of the Association. In the case of death, resignation or removal of the Speaker, the Vice-Speaker shall officiate during the unexpired term.

H. Expenses

The necessary expenses of the above officers incurred in the line of duty herein imposed shall be allowed for in the budget, but excepting the Executive Director, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII—TRUSTEES

Section 1—Composition/Voting Power

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except when the Trustee is not in attendance; and (2) ex officio, the President, President-Elect, Treasurer, Immediate Past President with power to vote, Assistant Treasurer without power to vote except in case the Treasurer is not in attendance, and the Speaker, [and] Vice-Speaker, and Executive Director without power to vote.

Section 2—Authority

The Board shall be the executive body of the Association, with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require, and perform and exercise all of the rights and duties as specified in this chapter.

Section 3—Election

Election—Trustee and Alternate. The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Director of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Section 4—Meetings and Terms

The Board shall meet as follows: 1. The Board shall meet at least once each quarter of the calendar year, the time, date and location to be fixed by the Board. 2. On the day preceding the first day for the scientific

meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the chairman, or on petition of three Trustees. It shall hold no meeting that will conflict with any meeting of the House of Delegates. Notice of each regular meeting shall be given at least ten days before such meeting.

Special meetings may be called at any time by the Chairman or at the request of seven members of the Board. Notice shall be given at least five days before each special meeting. The notice shall specify the general purpose of and business to be transacted at the meeting.

It shall elect a chairman, and a clerk, who, in the absence of the Executive Director of the Association, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Board shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of Trustees shall begin with the first meeting of the Board following the final session of the House of Delegates at the Annual Session.

The term of the elected Trustees shall be for three years and approximately one third of the number shall be elected annually. No Trustee shall be eligible to serve longer than two consecutive three-year terms.

Each Trustee district shall elect an Alternate Trustee whose term of office shall be for three years. The Alternate Trustee shall be elected in a year during which his Trustee is not elected. No alternate trustee shall be eligible to serve longer than two (2) consecutive three-year terms. The time given to serving an unexpired term shall not be considered in determining the period within which a trustee or alternate trustee may serve consecutively.

Section 5—Vacancies

In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any District Trustee, the duly elected Alternate Trustee from the same district shall succeed to the office of the Trustee in that District for the unexpired term of said Trustee. In the event vacancies occur in any Trustee District in the offices of both Trustee and Alternate Trustee, the vacancies shall be filled by an election by the members of the Association within the Trustee District in which the vacancies occur. A call for such elections shall be issued by the Executive Director of the State Association following a conference(s) with the officers of the District organization. The call shall state the time and place of holding the election and shall be sent registered mail to the County Secretary as filed in the State Director's Office of each component society within the District. Such call shall be mailed within ten days after the State Director has learned of the vacancies. The election may be held at a special or regular meeting at which business other than the election may be transacted. Such election shall be held within fifteen days after the Director of the State Association shall have mailed such call.

Section 6—Organization and Duties

A. Immediately following the conclusion of the annual convention, the Board shall organize by electing a Chairman and a Clerk. The Chairman of the Board of Trustees shall be an ex officio member of all ISMA standing commissions and committees.

The Board of Trustees at its organization meeting, by resolution adopted by a majority of the Trustees in office, may designate two Trustees or members of the Association to complete the Executive Committee. Members of the Committee shall serve until the next organization meeting of the Board and until their successors are elected and qualified. The Executive Committee shall have such powers and duties as may be defined from time to time by resolution of the Board of Trustees.

B. Quorum

Twelve members of the Board shall constitute a quorum.

C. Attendance at Meetings

If any elected Trustee fails, without reason acceptable to the Board, in any one calendar year to attend a majority of the meetings of the Board, he shall thereby cease to be a Trustee, and the Executive Director shall thereupon take action in accordance with Section 5, Vacancies.

D. Meeting Notices

Notice is given if delivered in person, by telephone, mail or telegram. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, addressed to a Trustee (and other persons entitled to notice) at his address then appearing on the records of the Association, with postage prepaid, and if given by telegraph, shall be deemed delivered when the telegram is delivered to the telegraph company.

Notice of any meeting and the object or business to be transacted at a meeting of the Board need not be given if waived in writing, or by telegraph, cable, or wireless before, during, or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting except where attendance is for the express purpose of objecting to the transacting of any business because the meeting is not lawfully called or convened.

E. Business of Association

The Board shall perform all acts and transact all business for or on behalf of the Association and manage the property and conduct the affairs, work and activities of the Association, except as may be otherwise provided in the Constitution or the Bylaws. All resolutions and recommendations of the House of Delegates including the expenditure of funds passed by the House of Delegates, shall be referred to the Board of Trustees which shall determine if the resolutions, recommendations or the expenditures are advisable. If it is decided that the resolution(s), recommendation(s), or the expenditure(s) is inadvisable, the Board shall report, at its earliest convenience, to the House of Delegates the reasons for its action.

F. Journal and Other Publications

The Board shall provide for the publication of and determine the editorial policies, in accordance with the policy enunciated by the House of Delegates, of (1) THE JOURNAL of the State Association, (2) publications as it may deem expedient, (3) a publication for public information and dissemination and (4) all proceedings, transactions and memoirs.

The Board shall provide for and superintend all publications of the Association, and shall appoint an editor and an editorial board, as it deems necessary, and fix the amount of their salaries. The proceedings of the Board for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Appoint an editor or editors for all of the Association's publications.

G. Employ Executive

Employ the Executive Director, and fill any vacancy therein, who shall be the person to manage and direct the activities of the Association under the authority granted by the Board.

H. Financial Reports

(1) Have the accounts of the Association audited at least annually.

(2) Make proper financial reports concerning Association affairs to the House at its annual convention.

I. County Visitations, Expenses and Reports

Each Trustee shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Trustee in the line of the duties herein imposed may be allowed by the Board on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

J. Organizing County Societies

The Board shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly relations among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

K. Scientific Work

The Board shall, through its officers and otherwise, given diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

The Board shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

L. Interests of the Profession

The Board shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

M. Charters

The Board shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

N. Board of Censors

The Board shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Trustee, and its decision in all such matters shall be final.

O. Election of At-Large Members to Executive Committee

The Board shall at its meeting following the close of the House of Delegates specify the duties and elect two members of the Association, at large, or of the Board, who, with the President, the President-elect, the Immediate Past President, the Treasurer, and the Chairman of the Board, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Board they shall not have the power to vote in the Board.

P. Duties of Alternate Trustee

The duties of the Alternate Trustee shall be:

(a) To represent the Trustee District when the regularly elected Trustee is not in attendance.

(b) To vote only when the Trustee is not in attendance either in the House of Delegates or in the Board meetings where he represents the regularly elected Trustee.

CHAPTER VIII—THE EXECUTIVE COMMITTEE

Section 1—Composition

The Executive Committee, constituted as provided in Chapter VII (O) of these Bylaws, shall hold its first meeting immediately following the meeting of the Board held at the close of the last meeting of the House of Delegates in the Annual Convention, and shall organize by electing its chairman. If the Executive Committee is unable to select a chairman within thirty (30) days after the final meeting of the House of Delegates, then a meeting of the Board of Trustees shall be called and a chairman of the Executive Committee shall be selected by the Board of Trustees. Its secretary shall be the Executive Director of the Association. It shall meet with the Executive Director on the call of the chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Director's office and such other duties as the Board may specify. It shall have all jurisdiction with respect to medical defense activities of the Association, and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Board, and shall report its actions to the Board.

Section 2—Budget Responsibility

It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or

officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Section 3—Investment of Surplus Funds

The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Board at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

Section 4—Student Loans

The Executive Committee shall have the authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. Rules and regulations adopted shall be subject to the approval of the Board. The Executive Director shall have the duty and responsibility of keeping minutes of all transactions and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

Section 5—Vacancy

A vacancy on the Executive Committee shall be filled by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

CHAPTER IX—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1—Creation of Committees and Commissions

The organization of the Association, the performance of which is not provided elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Board or of the House of Delegates, or by special committees created by the Executive Committee, the Board or the House of Delegates, may be performed by the following committees and commissions:

The Grievance Committee

The Future Planning Committee

The Medico-Legal Committee

The Commissions are as follows:

COMMISSION ON MEDICAL SERVICES

This Commission encompasses the fields of:

Emergency Medical Services

Aging

Public Health

Governmental Medical Service Programs

Voluntary Health Agencies

Sports and Medicine

Medical Economics and Insurance

COMMISSION ON MEDICAL EDUCATION

This Commission encompasses the fields of:

Licensure

Accreditation

Education Program

COMMISSION ON LEGISLATION

This Commission encompasses the fields of:

State Legislation

Federal Legislation

COMMISSION ON CONSTITUTION AND BYLAWS

COMMISSION ON PUBLIC RELATIONS

This Commission encompasses the fields of:

Public Information

Special Activities

Interprofessional Relations

COMMISSION ON CONVENTION ARRANGEMENTS

This Commission encompasses the fields of:
Specialty Medicine

Section 2—Committee Structure

Except as otherwise stated in the Bylaws, with specific reference to Chapter V, Section 8A, a Committee shall consist of not less than 4 nor more than 5 members, appointed from the general membership of the Association and shall be appointed annually by the President. The President shall also appoint the Chairman of each Committee. The committee chairman shall appoint a vice chairman.

Section 3—Commission Structure

The President may appoint one commission member for each 600 active members or major fraction thereof, but in any event, each district shall have one member on each commission. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise. The President shall appoint the chairman of each commission. The commission chairman shall appoint a vice chairman.

Section 4—Removal of Members

The President shall have the power, with the approval of the Board, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Section 5—Terms

Unless otherwise provided in these Bylaws, no member of a commission shall serve on the same commission more than two consecutive terms, but this shall not prevent his serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Section 6—Initial Meeting

Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. In these meetings the commissions may provide for such subcommissions within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Section 7—Coordination of Activities

Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Section 8—Duties and Responsibilities

Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

A. The Grievance Committee

—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Board of the State Association. It shall, subject to the approval of the Board, draw up a set of rules and regulations governing its procedure and official action.

B. The Future Planning Committee

—The function of this committee shall be to study and anticipate future trends and to stimulate the various commissions in coordinated directions so there is concord to the entire operation of Indiana State Medical Association. It is not contemplated that it be an operational committee.

C. The Medico-Legal Review Committee

—The Medico-Legal Review Committee shall consist of three members selected from the Indiana State Medical Association whose duty it shall be to meet in joint session and work with a similar committee of three members of the State Bar Association to be appointed by the Indiana State Bar Association. These three members of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association, and in all other medico-legal matters.

D. The Indiana Medical Education Fund Committee. The purpose of this committee shall be to promote, develop and improve medical education in the Indiana University School of Medicine for the general benefit of the entire public by obtaining and using funds from private sources to accomplish that result. The funds collected will be deposited in a trust and at periodic intervals the committee shall make a distribution from the trust to be used by the Indiana University School of Medicine. The Indiana Medical Education Fund Committee shall consist of eight persons. Five of whom shall be from the Indiana State Medical Association, appointed by the president thereof, all of whom shall be voting members. There shall be three additional members of the committee who shall be ex officio and non-voting and they shall be the Dean of the Indiana University School of Medicine, or his designee, the President of Indiana State Medical Association, and the Executive Director of the Association who shall also act as Secretary of the Committee. The actions of this committee shall be certified to the Executive Committee. Each year a report of the Committee's activities, including a financial accounting report of the fund itself as

administered by the trustee, shall be made part of the Executive Committee's annual report to the House of Delegates. The five members shall serve staggered terms to insure continuity. Two members shall be appointed to serve three (3) year terms, two shall serve two (2) year terms, and one shall serve a one year term.

E. The Impaired Physician Peer Review Committee.

—The Impaired Physician Peer Review Committee shall consist of five members selected from Indiana State Medical Association membership whose duty it shall be to develop a program to recognize, treat and rehabilitate physicians who are impaired by neuropsychiatric illness, physical infirmities or alcohol and other substance dependence. The committee will encourage informal and formal referral of impaired physicians through county medical society screening committees. The committee shall be responsible to develop a program in cooperation with the Indiana Medical Licensing Board using as a guide the Medical Practice Act.

F. Negotiations Committee. The Negotiations Committee shall consist of five physician members appointed for terms of four (4) years each. The initial nomination shall be staggered to insure continuity. Two members shall be appointed to four year terms. One member shall be appointed for a three year term and one member shall be appointed for a two year term and one member shall be appointed for a one year term. The purpose of the Negotiations Committee is to become involved in proposals which affect the practice of medicine that include, but not limited to, negotiating with third parties and various other government agencies at specific direction from the Board of Trustees.

G. The Commission on Medical Services

—The Commission on Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the government, plans and programs of the government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

H. The Commission on Medical Education

—The Commission on Medical Education shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

I. The Commission on Legislation

—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and the United States Congress, and with the legislative

activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

J. The Commission on Constitution and Bylaws

—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

K. The Commission on Public Relations

—The Commission on Public Relations shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

L. The Commission on Convention Arrangements

—The Commission on Convention Arrangements, with the advice and assistance of the Executive Director, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Board, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Director, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Director of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the Annual Convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the Annual Convention.

—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

Section 9—Ex Officio Members

The President, President-elect, Executive Director, Speaker and Vice-Speaker of the House shall be ex officio members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER X—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of reelection.

CHAPTER XI—REFERENDUM

Section 1—Procedure

A general meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

CHAPTER XII—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

DIVISION FOUR— COUNTY AND DISTRICT SOCIETIES

CHAPTER XIII—COUNTY SOCIETIES

Section 1—Charters

—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

—Charters shall be issued only upon approval of the Board and shall be signed by the President and Executive Director of this Association. The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Trustee for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Board, which shall decide what action shall be taken.

Section 2—Membership Qualifications

—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine, a degree of Bachelor of Medicine or who holds a valid, unrestricted license to practice medicine and surg-

ery, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be eligible for membership. Provided, however, that each county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association or for a violation of the Principles of Medical Ethics of the Indiana State Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Section 3—Right of Appeal

—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Board, and its decision shall be final.

—In hearing appeals the Board may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Trustees in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 4—Membership Transfer

—When a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed.

—A physician who has the major part of his practice in a county other than the county in which he resides may hold his membership in the county society of his residence or in the county society of the county in which he has the major part of his practice. However, no physician shall hold active membership in more than one county society at the same time.

Section 5—Direction of Profession

—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Section 6—Selection of Delegates

—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Director of this Association annually on or before February 1.

Section 7—Secretarial Duties

—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by re-

moval to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Trustee of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Trustee shall also be sent to the Executive Director of the State Association. The State Association shall supply each county secretary a form for these reports.

Section 8—Fiscal Year and Dues

—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

Unless collected by the Indiana State Medical Association, the secretary of each component society shall forward the dues for his society to the Executive Director of this Association and shall furnish the State Association Headquarters with a roster of officers, members and a listing of non-affiliated physicians of the county, on or before January 1 of each year, and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Director of this Association the dues for such members.

The dues and the rights and benefits of all members shall be as provided in Chapter I, Section I, et seq. of the bylaws.

Provided, however, that physicians elected to their first membership in this Association during the first six months of any year shall pay the regular annual dues for that year; and those elected to their first membership after July 1 of any one year shall pay fifty percent of the annual dues as dues for the remainder of that year. Interns and residents shall pay annual dues during their term of service in the hospital at a reduced rate established by the Board of Trustees.

In the event the county society relieves a member from the payment of dues on account of financial hardship, the secretary of the county medical society shall recommend in writing to the Trustee of his district the relief from State Association dues of said member of the society, showing why such recommendation should be granted. The Trustee in turn shall present the recommendation to the Board, which shall have the power to relieve a member of dues.

Section 9—Failure to Pay Dues

—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 10—Secretary Direction

—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Section 11—Constitution and Bylaws

—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Director of the Indiana State Medical Association not later than

May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Director.

CHAPTER XIV—

TRUSTEE DISTRICT MEDICAL SOCIETIES

Section 1—Composition

—A Trustee District Medical Society, hereinafter called the district society, shall be a society whose members consist of the members of the county medical societies in the counties which constitute the Trustee district.

Section 2—Number of Districts

—The state shall be divided into thirteen (13) Trustee districts with the boundary lines and numbers of each district to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Batholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton, White, Newton and Jasper Counties.

Tenth District—Porter and Lake Counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami, and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Section 3—Constitution and Bylaws

—Each district society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one district society shall exist within any one Trustee district. The authorized district society in each Trustee district shall receive a charter from the State Association, and the secretary of the district society shall have custody of the charter.

Section 4—Officers

—Each district society shall organize by electing a president, a secretary and a treasurer and Trustee(s) and Alternate Trustee(s) as the current Trustee(s) term and Alternate Trustee(s) term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of secretary and treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Section 5—Trustee Allocation

—Each district society shall have one Trustee and one Alternate Trustee for each 600 active members or major

fraction thereof but in any event each district shall have one Trustee and one Alternate Trustee. The term of each trusteeship newly created by the numerical growth of a district shall begin at the organization meeting of the Board immediately following the adjournment of the second meeting of the House of Delegates at the next annual meeting, in accordance with Chapter VII, Section 6A.

Section 6—Dues

—The dues of the district society, in an amount fixed by the district society to meet the society needs, shall be collected by the secretaries of the component county societies, or by the Indiana State Medical Association and delivered to the treasurer of the district society. The secretary of each district society shall report to the office of the Indiana State Medical Association the names and addresses of the members of his district society, together with a copy of the minutes of each meeting of his district society.

Section 7—Meetings

—Each district society shall meet at least once each year at a time and place to be fixed by the district society. On or before January 1 of each year each district society shall notify the headquarters of the State Association of the time and place of the annual district meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Board, the Trustee shall fix the time and place of the district meeting, and notice of such meeting shall be sent to the members of the county medical societies in such district.

Section 8—Notification to Headquarters

—Whenever a district society is to elect a Trustee and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such district society not later than the first of March of the year in which the election is to occur.

—The district society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the district of the meeting at least thirty (30) days prior to the date thereof.

Section 9—Recommendation of Nominees to the Board of Directors of Mutual Medical Insurance, Inc.

Each district medical society may recommend nominees from its membership (a physician subscriber to Mutual Medical Insurance, Inc.) to serve on the Board of Directors of MMI. The physician recommended will be submitted for nomination at the annual meeting of Mutual Medical Insurance, Inc. In addition ISMA Board of Trustees may recommend additional nominees.

DIVISION FIVE—MEDICAL DEFENSE

CHAPTER XV—MEDICAL DEFENSE ADMINISTRATION, AUTHORITY AND PROCEDURES

Section 1—Administration

—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Section 2—Authority

—This committee shall have full authority governing all matters pertaining to this Chapter. In order to insure a fair and full presentation of defense for any member physician sued or against whom claim is made, the com-

mittee shall have the power to employ and pay an attorney of their choice as a consultant to the committee, and such other expenses as the committee may approve as necessary. It is expected that the committee's consultant attorney will provide necessary communication with the member-physician's personal attorney.

Section 3—Annual Report

—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Section 4—Liability

—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal consultation for its members as may be incurred in accordance with the terms of these Bylaws.

Section 5—Eligibility

—The Association shall not undertake the consultation of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Director, shall be considered the only bona fide evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense consultation against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services, which are the basis of the suit, were rendered.

Section 6—Filing for Defense

—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Director of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the president, secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Section 7—County Society Committee

—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Section 8—Appeal

—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Section 9—Deceased Member

—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Section 10—Locality Restrictions

—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Section 11—Adoption of Rules

—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Section 12—Terms of Defense

—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

DIVISION SIX—MISCELLANEOUS

CHAPTER XVI—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XVII—PARLIAMENTARY PROCEDURE

—The deliberations of this Association shall be governed by parliamentary usage as prescribed in the current edition of Sturgis Standard Code of Parliamentary Procedure, when not in conflict with this Constitution and Bylaws.

CHAPTER XVIII—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention. Amendments to the Bylaws must be submitted to the Commission on Constitution and Bylaws 30 days in advance of the Annual Convention. These amendments must be presented by the Commission on Constitution and Bylaws and are eligible for passage after lying on the table for one day. Any other Bylaw amendments presented to the House of Delegates at the time of the Annual Convention will not be eligible for consideration by the House of Delegates until the next annual meeting unless a two-thirds majority of the House votes to consider the amendment as presented.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

CHAPTER XIX—MEDICAL ETHICS

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Principles of Medical Ethics of the American Medical Association

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to inter-

fere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the equality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

THE JOURNAL

of the

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

•

EDITOR

FRANK B. RAMSEY, M.D., Indianapolis

CONSULTING EDITORS

A. W. CAVINS, M.D., Terre Haute
SAMUEL R. MERCER, M.D., Fort Wayne
LALL G. MONTGOMERY, M.D., Muncie
IRVIN W. WILKENS, M.D., Indianapolis
W. D. SNIVELY, Jr., M.D., Evansville
CHARLES A. BONSETT, M.D., Indianapolis

EDITORIAL BOARD

ALVIN J. HALEY, M.D., Fort Wayne
WEI-PING LOH, M.D., Gary
STEVEN C. BEERING, M.D., Indianapolis
ELTON HEATON, M.D., Madison
PAUL S. RHOADS, M.D., Richmond
RODNEY A. MANNION, M.D., LaPorte

MANAGING EDITOR

MARTIN T. BADGER, Indianapolis

BUSINESS MANAGER

DONALD F. FOY, Indianapolis

•

Office of Publication: 3935 North Meridian Street, Indianapolis 46208

INDEX TO VOLUME 71

January through December 1978

January	1 - 64
February	65 - 128
March	129 - 358
April	359 - 432
May	433 - 514
June	515 - 638

July	639 - 724
August	725 - 800
September	801 - 942
October	943 - 1022
November	1023 - 1098
December	1099 - 1254

Index to Volume 71

The Journal of the Indiana State Medical Association

SCIENTIFIC ARTICLES

A

- A Re-Evaluation of Ephedrine/Theophylline Combinations in the Treatment of Asthma (Caplin-Haynes) 492
- A Simplified Approach to Dysfunctional Uterine Bleeding (Bonaventura-Cleary) 831
- A Study in Longevity (Swaim) 771
- Abdominal Aortic Aneurysm, Rupture of, into Vena Cava: A Report of Two Cases (Siderys-Okorafor) 90
- Abdominal Pregnancy, Full Term: A Case Report and Review of Literature (Banguis-Jean) 330
- Addiction, Nicotine: Treatment with Medical Hypnosis (Grosz), Part 1 1074
- Part 2 1136
- Alcoholic, The Physician—Arch to Recovery (Ayres) 398
- Aldosteronism, Primary (Hypertension VII) (Ganguly) .. 31
- Appendix, Tolerance of the Vermiform, to Pressure (Noveroske) 1144
- Arterial Reconstructive Surgery, Successful, Heel Ulcer Development and 1142
- Asthma, A Re-Evaluation of Ephedrine/Theophylline Combinations in the Treatment of (Caplin-Haynes) .. 492
- Asymmetry of Positional Deformities in the Newborn Infant (Conway) 101
- Atherosclerosis, HDL Cholesterol and (Powell) 551

B

- Blood Flow Studies, Non-Invasive, for Evaluating the Arterial and Venous Systems of the Legs and the Extracranial Carotid System in the Neck (Hilz-Napier-Kiggins-Hamm) 563
- Blood Test, PKU and Hypothyroidism, for Newborn Infants (Brandt) 329

C

- Catheter Complications with Total Parenteral Nutrition in the First Year of Life (Smitherman, Ballantine, Grosfeld) Part 1 478
- Part 2 554
- Civil Liability, Potential, of the Physician, Teratogenicity of Rubella Vaccine Virus (Connaughton) 21
- Clinical Notes: Dermatology (Guin) 333, 557
- Coagulative Integrity of the Surgical Patient, Platelet Studies as a Measure of (Rohn-Campbell-Clark) 325
- Colon/Rectum Cancer, Screening for (McDougal-Williams-Astesano) 411
- Complications of Acute Anterior Myocardial Infarction (Noble-Hillis) 470
- Congenital Hypothyroidism, Screening for, Using an Insolubilized Radio Immunoassay Technique (Oei, Wynn, Nordschow, Ryder, Hoke) 689
- Contraceptives, Oral, and Thromboembolic Disease (Hall-Mandelbaum-Hall) 413
- Coronal Pregnancy: A Case Report (Porter-Wambo) 94
- Coronary Artery Endarterectomy: Its Role in Myocardial Revascularization (Siderys) 835

- Creation of Pelvic Tamponade by Deliberate Ureteral Obstruction in Treatment of Intractable Unilateral Renal Bleeding (Mannion) 336
- Current Concepts in the Evaluation and Treatment of Hodgkin's Disease (Williams-Einhorn) 402
- Current Concepts in the Management of Pulmonary Tuberculosis (Ziegler-Jay-Brashear) 763

D

- Deformities, Positional, Asymmetry of, in the Newborn Infant (Conway) 101
- Depression in the Elderly (Blix-Hendrie) 983
- Dermatology, Clinical Notes (Guin) 333, 557
- Diabetes, Practical Management of, for Family Practitioners (Clark) 1063
- Diabetic Mothers, Infants of (Stevens-Schreiner) 409
- Diatheses, Hemorrhagic: Diagnosis and Management (Ahmadzai) 756
- Disease, Legionnaire's (White) 35
- Dysfunctional Uterine Bleeding, A Simplified Approach to (Bonaventura-Cleary) 831

E

- Ear Surgery, Reconstructive (Hicks-Wright-Wright) 694

F

- Further Observations on New Tube Tests for Rapid Detection of Hemoglobin S (Loh-Hicks) 692

H

- HDL Cholesterol and Atherosclerosis (Powell) 551
- Heel Ulcer Development and Successful Arterial Reconstructive Surgery (Rolley) 1142
- Hemoglobin S, Further Observations on New Tube Tests for Rapid Detection of (Loh, Hicks) 692
- Hemorrhagic Diatheses: Diagnosis and Management (Ahmadzai) 756
- Hodgkin's Disease, Current Concepts in the Evaluation and Treatment of (Williams-Einhorn) 402
- Hypertension VII: Primary Aldosteronism (Ganguly) 31
- Hypertension VIII: Hypertension in the Patient with Renal Failure (Luft) 104
- Hypertension IX: Pheochromocytoma: Diagnosis and Management (Pratt) 1076
- Hypertension X: Renovascular Hypertension: How to Make the Diagnosis in Your Office (Grim) 1133
- Hypnosis, Medical: Nicotine Addiction: Treatment with (Grosz) Part 1 1074
- Part 2 1136
- Hypoglycemia, Neonatal (Stevens-Schreiner) 485
- Hypnatremia, The Treatment of (Rahmany) 488
- Hypothyroidism, and PKU, Blood Test for Newborn Infants (Brandt) 329

Index to Volume 71

I	
Immunoblastic Lymphadenopathy (Tsung)	1068
Infantile Rickets (Stadler)	1072
Infant and Child Automobile Safety, Physician Alert (Alexander)	558
Infants of Diabetic Mothers (Stevens-Schreiner)	409
Infants Fail to Thrive, Why Some: A Problem with Serious Implications	1129
K	
Kyphosis, Scoliosis and Lordosis, Spinal Screening for (Rapp)	33
L	
Legionnaire's Disease: A Case Report with Review of Literature (Loh)	994
Legionnaire's Disease (White)	35
Liability, Potential Civil, of the Physician, Teratogenicity of Rubella Vaccine Virus (Connaughton)	21
Longevity, A Study in (Swaim)	771
Lordosis, Kyphosis, Scoliosis, Spinal Screening for (Rapp)	33
Lymphadenopathy, Immunoblastic (Tsung)	1068
M	
Major Abdominal Vascular Injury, Survival Rates of, in an Eight-Year Period (Yaw-Zahm-Glover)	776
Myocardial Infarction, Acute Anterior, Complications of (Noble-Hillis)	470
Myocardial Revascularization, Its Role in: Coronary Artery Endarterectomy (Siderys)	835
N	
Necrotizing Enterocolitis in the Newborn: Analysis of 32 Cases (Stein-Schreiner-Ballantine-Grosfeld-Gresham) ..	393
Neonatal Hypoglycemia (Stevens-Schreiner)	485
Newborn Infant, Asymmetry of Positional Deformities in (Conway)	101
Newborn Infants, PKU and Hypothyroidism Blood Test for (Brandt)	329
Newborn, Necrotizing Enterocolitis in the: Analysis of 32 Cases (Stein-Schreiner-Ballantine-Grosfeld-Gresham) ..	393
Newborn Thyroid Screening: Rationale, Methods, Responsibilities (Wynn-Oei-Wright-Schreiner)	686
Nicotine Addiction: Treatment with Medical Hypnosis (Grosz) Part 1	1074
Part 2	1136
Non-Invasive Blood Flow Studies for Evaluating the Arterial and Venous Systems of the Legs and the Extracranial Carotid System in the Neck (Hilz-Napier-Kiggins-Hamm)	563
Notes on Thyroid Disease (Frank)	108
O	
Oral Contraceptives and Thromboembolic Disease (Hall-Mandelbaum-Hall)	413
P	
Pelvic Tamponade, Creation of, by Deliberate Ureteral Obstruction in Treatment of Intractable Unilateral Renal Bleeding (Mannion)	336
Pheochromocytoma: Diagnosis and Management, Hypertension IX (Pratt)	1076
Physician Alert: Infant and Child Automobile Safety (Alexander)	558
PKU and Hypothyroidism Blood Test for Newborn Infants (Brandt)	329
Platelet Studies as a Measure of Coagulative Integrity of the Surgical Patient (Rohn-Campbell-Clark)	325
Plication of Rectal Mucosa (Appel)	684
Poison Ivy (Rhus) Dermatitis (Guin)	774
Positional Deformities in the Newborn Infant, Asymmetry of (Conway)	101
Practical Management of Diabetes for Family Practitioners (Clark)	1063
Pregnancy, Abdominal, Full Term: A Case Report and Review of Literature (Banguis-Jean)	330
Pregnancy, Cornual: A Case Report (Porter-Wambo)	94
Primary Aldosteronism (Hypertension VII) (Ganguly) ..	31
Psychotherapy: What Is It? (Wehlage)	1079
Pulmonary Screening: Current Application (Ayoub) ..	334
Pulmonary Tuberculosis, Current Concepts in the Management of (Ziegler-Jay-Brashear)	763
Pulmonary Tuberculosis Patients Receiving Steroids, Surgical Experience with (Chua, Zvetina, Raghunath, Neville, Pifarre)	1138
R	
Radiation-Associated Thyroid Cancer (Roudebush-Asteris) ..	780
Raynaud's Phenomenon: Treatment of a Severe Case with Biofeedback (Adair-Theobald)	990
Reconstructive Ear Surgery (Hicks-Wright-Wright)	694
Reconstructive Surgery, Heel Ulcer Development and Successful Arterial (Rolley)	1142
Rectal Mucosa, Plication of (Appel)	684
Renal Bleeding, Creation of Pelvic Tamponade by Deliberate Ureteral Obstruction in Treatment of Intractable Unilateral (Mannion)	336
Renal Failure, Hypertension in the Patient with (Luft) ..	104
Renovascular Hypertension: How to Make the Diagnosis in Your Office (Grim) Hypertension X	1133
Rickets, Infantile (Stadler)	1072
Rubella Vaccine Virus, Teratogenicity of and Potential Civil Liability of the Physician (Connaughton)	21
Rupture of Abdominal Aortic Aneurysm into Vena Cava: A Report of Two Cases (Siderys-Okorafor)	90
S	
Scoliosis, Kyphosis and Lordosis, Spinal Screening for (Rapp)	33
Screening for Colon/Rectum Cancer (McDougal-Williams-Astesano)	411
Screening for Congenital Hypothyroidism Using an Insolubilized Radio Immunoassay Technique (Oei-Wynn-Nordschow-Ryder-Hoke)	689
Screening, Pulmonary: Current Application (Ayoub)	334
Screening, Spinal, for Scoliosis, Kyphosis and Lordosis (Rapp)	33
Spider Bite, The Brown Recluse: New Problems, New Therapy (Anderson)	681
Spinal Screening for Scoliosis, Kyphosis and Lordosis (Rapp)	33

Steroids, Surgical Experience with Pulmonary Tuberculosis Patients Receiving (Chua, Zvetina, Raghunath, Neville, Pifarre)1138

Surgical Experience with Pulmonary Tuberculosis Patients Receiving Steroids (Chua, Zvetina, Raghunath, Neville, Pifarre)1138

Survival Rates of Major Abdominal Vascular Injury in an Eight-Year Period (Yaw-Zahm-Glover) 776

T

Teratogenicity of Rubella Vaccine Virus and Potential Civil Liability of the Physician (Connaughton) 21

The Brown Recluse Spider Bite: New Problems, New Therapy (Anderson) 681

The Causes and Medical Treatment of Urinary Calculi (Bloch-Luft) 678

The Fountain of Youth or Where is the Estrogen Coming From (Porter-Wambo-Wiland) 997

The Physician Alcoholic—Arch to Recovery (Ayres) 398

The Treatment of Hyponatremia (Rahmany) 488

The Treatment of Urticaria (Guin) 700

Thromboembolic Disease, Oral Contraceptives and (Hall-Mandelbaum-Hall) 413

Thyroid Cancer, Radiation-Associated (Roudebush-Asteris) 780

Thyroid Disease, Notes on (Frank) 108

Thyroid Function Tests for the Practicing Physician (Roudebush-Asteris) 837

Thyroid Screening, Newborn: Rationale, Methods, Responsibilities (Wynn-Oei-Wright-Schreiner) 686

Tolerance of the Vermiform Appendix to Pressure (Noveroske)1144

Tuberculosis, Pulmonary, Patients Receiving Steroids Surgical Experience with (Chua, Zvetina, Raghunath, Neville, Pifarre)1138

U-V-W

Ulcer Development, Heel, and Successful Arterial Reconstructive Surgery (Rolley)1142

Urinary Calculi, The Causes and Medical Treatment of (Bloch-Luft) 678

Urticaria, The Treatment of (Guin) 700

Uterine Bleeding, Dysfunctional, A Simplified Approach to (Bonaventura-Cleary) 831

Vena Cava, Rupture of Abdominal Aortic Aneurysm into: A Report of Two Cases (Siderys-Okorafor) 90

Vermiform Appendix, Tolerance of the, to Pressure (Noveroske)1144

Virus, Teratogenicity of Rubella Vaccine, and Potential Civil Liability of the Physician (Connaughton) 21

HYPERTENSION

Hypertension in the Patient with Renal Failure (Luft) 104

Pheochromocytoma: Diagnosis and Management (Pratt) ..1076

Primary Aldosteronism (Ganguly) 31

Renovascular Hypertension: How to Make the Diagnosis in Your Office (Grim)1133

NOTES FROM THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

Notes from the Royal College of Surgeons of England (Herring)16, 841

CONTINUING MEDICAL EDUCATION SERIES (AMA Category 1 Credit)

A Simplified Approach to Dysfunctional Uterine Bleeding (Bonaventura-Cleary) 831

Complications of Acute Anterior Myocardial Infarction (Noble-Hillis) 470

Current Concepts in the Management of Pulmonary Tuberculosis (Ziegler-Jay-Brashear) 763

Depression in the Elderly (Blix-Hendrie) 983

HDL Cholesterol and Atherosclerosis (Powell) 551

Hemorrhagic Diatheses: Diagnosis and Management (Admadzai) 756

Legionnaire's Disease (White) 35

Platelet Studies as a Measure of Coagulative Integrity of the Surgical Patient (Rohn-Campbell-Clark) 325

Practical Management of Diabetes for Family Practitioners (Clark)1063

The Causes and Medical Treatment of Urinary Calculi (Bloch-Luft) 678

Why Some Infants Fail to Thrive: A Problem with Serious Implications (Green)1129

THE SCALPEL AND THE PEN

Tobias George Smollett (Mannion) 706

Francois Rabelais (Mannion)1004

SEMINARS FROM RILEY CHILDREN'S HOSPITAL

Infants of Diabetic Mothers (Stevens-Schreiner) 409

Neonatal Hypoglycemia (Stevens-Schreiner) 485

EDITORIALS

A Deterrent to Government Price Controls (AMA) 646

Health Costs and National Health Insurance 526

Cost Containment: Where the Monkey Is (Manning) 953

Costs More, Gives Less 70

Guest Editorial (Lukemeyer) 77

Health, Hospital Care Survey Results 807

Indiana Jail Project 305

Indianapolis Museum of Art1030

Is American Medicine Noncompetitive?1104

Limitless Demand? 6

M.D. 1978: The Tarnished Image (Arata) 648

Medical Care: Individual vs. Political (Arata) 520

Medical Claims 8

National Health Insurance 6

New Breast X-Ray Rules 305

On Rights and Justice (Arata)1110

Present for Duty, Sir! (Johnson) 956

Psychoactive Drugs 8

Second Opinion and Unnecessary Surgery 730

Survey of Canadian NHI1104

Texas, California Medicaid Program1030

The Bitter Fruits of a Coal Strike (Lukemeyer) 440

The Declining U.S. Economy (Arata) 813

The High Cost of Medical Care1030

The Physician: An Endangered Species (Arata) 364

The Poor—and the Poor Taxpayer (Arata) 954

The Quality of Drugs 730

The Uplavici Syndrome 68

Up with 'Polyvim'—Down with 'Heterosis' (Noveroske) .. 522

Index to Volume 71

DEPARTMENTS

About The Cover	4, 66, 302, 360, 436, 518, 642, 728, 804, 946, 1026, 1102
Book Reviews	38, 122, 342, 423, 504, 576, 712, 790, 855, 1008, 1087, 1148
British Browsings (Baker)	1002
Cancer Corner (Dugan)	84, 320, 454, 536, 702, 847, 980, 1116
Editorial Notes	15, 70, 308, 362, 438, 644, 731, 808, 948, 1035, 1106
From the Journal 50 Years Ago	43, 81, 318, 422, 446, 525, 673, 751, 843, 1012, 1124
Future File	51, 116, 347, 418, 496, 570, 710, 849, 1010, 1084, 1126
IMPAC: As I See It	663, 861
Letters	445, 958, 1096
Medical Museum Notes (Bonsett)	2, 65, 301, 359, 434, 515, 640, 725, 802, 943, 1028, 1099
Month in Washington	13, 78, 313, 372, 448, 530, 652, 738
News Notes	44, 112, 348, 419, 501, 572, 714, 786, 857, 1013, 1089, 1152
Notes from Down Under (Johnstone)	80, 754
Obituaries	61, 126, 512, 580, 722, 798, 940, 1020, 1096, 1160
Tax Tips (Jegen)	111, 342, 376, 538, 671, 742, 820, 975, 1043, 1114
The Auxiliary Reports	49, 121, 384, 458, 571, 666, 748, 844, 1057, 1112
There's A Word for It (Noveroske)	
Brachiocephalic Artery	378
Collapse of a Lung	18
Disease	746
Distal Expansion of the Radius	464
Gas-Liquid Level	328
Hip Bone	77
Low Sodium Diet	1012
Radiology	705
Scaphoid Bone	746
Technologist	1122
What's New?	1, 72, 306, 366, 433, 516, 639, 726, 801, 944, 1024, 1100

HUMAN INTEREST FEATURES

An Old-Time Approach: Dr. Henry R. Shallenberger	1120
Fort Wayne's Woman Doctor: Dr. Priya Shah	544
From Jasper to Africa . . . and Back: Dr. Charles H. Klammer	674
He's the Marcus Welby of Lafayette: Dr. Edward B. Ruschli	427
'Oh, Doc's a Good Guy': Dr. John A. Davis	752
Opposition Didn't Stop Her: Dr. Elizabeth Sowa	1054
Retirement—Perhaps His Greatest Challenge: Dr. Harry W. Salon	826
Surgeon Likes Immediate Results: Dr. Shirley Price	1055
That Certain Sparkle: Dr. James M. Pfeifer	978
The Dean of New Albany's Physicians: Dr. William H. Garner, Sr.	462

SPECIAL FEATURES

A Message for Reference Committee Members (Hill)	659
A Preview: Convention '78	815
A Survey of Three Western Indiana Rural Community Health Centers (Waldrop)	381
Coffee: Good for What Ails You? (Stevenson)	96
Commentary: A Good Death (Will)	734
Emergency Medical Council Ready	814
Floyd County Medical Society Centennial	460
IMPAC: A Special Report (Miles)	388
Index to Volume 71	1243
Index to 1978 Yearbook	583
Indiana Paramedic Ambulance Personnel Gain State Certification (Johnson)	964
Indiana's First Case of Malpractice—Hoosier Folklore (Gallinatti)	340
ISMA's New President: Dr. James A. Harshman	1036
ISMA Target: Insurance Coverage	1053
National Cancer Program (Upton)	732
North Central Indiana Physician Distribution and Projection Study (Troeger-Birdsell)	567
One Doctor's Rx for a Malpractice Lawsuit: Countersue (Shula)	106
Physician Fees: Overtaken by Inflation	1046
Public Attitude Survey—79% of Hoosiers Support Deductibles	1122
Reflections by the Chairman of a Surgical Audit Committee (Friedman)	731
Sterilization Restrictions: A Critique of Rules Proposed by DHEW (Moss)	390
Task Force on Health Care Costs Formed: Indiana Voluntary Effort	650
The Citizens's Power is Being Undermined by Federal Action (Bowen)	660
The I.U. Physician: 1903-1978 (Bonsett)	968
The Impaired Physician: A Treatable Problem	1058
The Washington Monument Ploy (Leshner)	1038
Why Does the Earth Turn? (Noveroske)	1048

MEMBERSHIP ROSTER SUPPLEMENT

Alphabetical	3/129
By Counties	143/269
County Medical Society Officers	173/299
ISMA Committees and Commissions	174/300
ISMA Honorary Members	142/268
ISMA Officers, Trustees, Alternate Trustees, Section Officers, Delegates to AMA, and Trustee District Officers, and Annual Meeting Dates	172/298
Medical Service Representatives, Indianapolis Chapter, Indiana Society	168/294
Medical Specialty Codes	142/268

YEARBOOK

Accredited Schools of Practice Nursing	621
Accredited Schools of Professional Nursing	620
Ambulatory Outpatient Surgical Centers	603
Approved Hospitals	599

Community Agencies for the Mentally Retarded and Other Developmentally Disabled	607
Community Mental Health Services	596
County Medical Society Directory	635
Deaths of Indiana Physicians in 1977	637
Disease Prevention by Immunization and Chemoprophylaxis	624
Federally Approved Home Health Service Agencies	604
Federally Approved Rehabilitation Centers	598
ISMA Committees and Commissions	634
ISMA Membership Report for 1977	637
ISMA Officers, Trustees and Section Officers	633
Independent Laboratories in the Medicare/Medicaid Program	605
Indiana Delegation in Congress; State Officials	584
Indiana Licensed Health Facilities	609
Indiana State Medical Association Auxiliary	632
Indiana University School of Medicine (Department Heads)	619
Ivy Tech Health Occupation Courses	622
Official Yellow Fever Vaccination Centers	623
Poison Control Centers in Indiana and Adjacent States	630
Presidents of ISMA Since Its Organization	638
Professional Medical and Allied Organizations	590
State Health Organizations	585
Voluntary Health Agencies	594

CONVENTION ISSUE

Convention Arrangements Commission	890
County Medical Society Directory	927
Delegates to the AMA	876, 941
50-Year Club	890
Guest Speakers	891
House of Delegates	867
Officers of ISMA, 1977-78	872, 941
Official Call to the House of Delegates	866
Program, Auxiliary	937
Reference Committees	928
Reports of Ad Hoc Committees	918
Reports of Commissions	906
Reports of Committees	914
Reports of Officers	895
Reports of Trustees	921
Resolutions	929
Schedule of Events	881
Scientific Exhibits	933
Section Officers	878, 941
Technical Exhibits	936
Trustees and Alternates	874, 941

1978 CONVENTION

AMA Principles of Medical Ethics	1241
Constitution and Bylaws of ISMA	1226
Dr. Arvine G. Popplewell Named President-Elect	1154
Index—Proceedings of the House of Delegates	1170
The 129th Convention in Pictures	1161

AUTHORS

A

Adair, Jack R., M.D. (Raynaud's Phenomenon: Treatment of a Severe Case with Biofeedback)	990
Ahmadzai, Ahmed Sami, M.D. (Hemorrhagic Diatheses) ..	756

Alexander, Jeffrey, M.D. (Physician Alert: Infant and Child Automobile Safety)	558
Anderson, Philip C., M.D. (The Brown Recluse Spider Bite: New Problems, New Therapy)	681
Appel, Richard H., M.D. (Plication of Rectal Mucosa) ..	684
Arata, L. A., M.D. (Guest Editorials:	
The Physician: An Endangered Species	364
Medical Care: Individual vs. Political	520
M.D. 1978: The Tarnished Image	648
On Rights and Justice	1110
The Declining U.S. Economy	813
The Poor—And the Poor Taxpayer)	954
Asteris, George T., M.D. (Radiation-Associated Thyroid Cancer)	780
Asteris, George T., M.D. (Thyroid Function Tests for the Practicing Physician)	837
Astesano, Rose (Screening for Colon/Rectum Cancer) ...	411
Ayoub, Adel H., M.D. (Pulmonary Screening: Current Application)	334
Ayres, Perry R., M.D. (The Physician Alcoholic—Arch to Recovery)	398

B

Baker, Duke H., M.D. (British Browsings)	1002
Ballantine, T. V. N., M.D. (Necrotizing Enterocolitis in the Newborn: Analysis of 32 Cases)	393
Ballantine, Thomas V. N., M.D. (Catheter Complications with Total Parenteral Nutrition in the First Year of Life) Part One	478
Part Two	554
Banguis, Eliseo T., M.D. (Abdominal Pregnancy, Full Term: A Case Report and Review of Literature)	330
Birdsell, Roger, Jr., M.B.A. (North Central Indiana Physician Distribution and Projection Study)	567
Blix, Susanne, M.D. (Depression in the Elderly)	983
Bloch, Richard, M.D. (The Causes and Medical Treatment of Urinary Calculi)	678
Bonaventura, Leo M., M.D. (A Simplified Approach to Dysfunctional Uterine Bleeding)	831
Bonsett, Charles A., M.D. (Medical Museum Notes) 2, 65, 301,	359, 434, 515, 640, 725, 802, 943, 1028, 1099
Bonsett, Charles A., M.D. (The I. U. Physician: 1903-1978)	968
Bowen, Otis R., M.D. (Speech: The Citizen's Power is Being Undermined by Federal Action)	660
Brandt, Ira K., M.D. (PKU and Hypothyroidism Blood Test for Newborn Infants)	329
Brashear, Richard E., M.D. (Current Concepts in the Management of Pulmonary Tuberculosis)	763
Brown, Priscilla, M.A. (The I. U. Physician: 1903-1978) ..	968

C

Campbell, Robert L., M.D. (Platelet Studies as a Measure of Coagulative Integrity of the Surgical Patient)	325
Caplin, Irvin, M.D. (A Re-Evaluation of Ephedrine/Theophylline Combinations in the Treatment of Asthma) ...	492
Chua, Felipe S., M.D. (Surgical Experience with Pulmonary Patients Receiving Steroids)	1138
Clark, Charles M., Jr., M.D. (Practical Management of Diabetes for Family Practitioners—Eleventh Continuing Medical Education Article)	1063
Clark, Joanne C. (Platelet Studies as a Measure of Coagulative Integrity of the Surgical Patient)	325
Cleary, Robert E., M.D. (A Simplified Approach to Dysfunctional Uterine Bleeding)	831

Index to Volume 71

- Connaughton, John, J.D., L.L.M. (Teratogenicity of Rubella Vaccine Virus and Potential Civil Liability of the Physician) 21
- Conway, Thomas J., M.D. (Asymmetry of Positional Deformities in the Newborn Infant) 101

D

- Dugan, William M., M.D. (Cancer Corner) 84, 320, 454, 536, 702, 847, 980, 1116

E

- Einhorn, Lawrence H., M.D. (Current Concepts in the Evaluation and Treatment of Hodgkin's Disease) 402

F

- Frank, John R. (Notes on Thyroid Disease) 108
- Friedman, Morris S., M.D. (Reflections by the Chairman of a Surgical Audit Committee) 731

G

- Gallinatti, John J., M.D. (Indiana's First Case of Malpractice—Hoosier Folklore) 340
- Ganguly, Arunabha, M.D. (Hypertension VII: Primary Aldosteronism) 31
- Glover, John L., M.D. (Survival Rates of Major Abdominal Vascular Injury in an Eight-Year Period) 776
- Green, Morris, M.D. (Why Some Infants Fail to Thrive: A Problem with Serious Implications) 1129
- Gresham, E. L., M.D. (Necrotizing Enterocolitis in the Newborn: Analysis of 32 Cases) 393
- Grim, Clarence E., M.D. (Renovascular Hypertension: How to Make the Diagnosis in Your Office) 1133
- Grosfeld, Jay L., M.D. (Catheter Complications with Total Parenteral Nutrition in the First Year of Life) Part 1 .. 478
Part 2 554
- Grosfeld, Jay L., M.D. (Necrotizing Enterocolitis in the Newborn: Analysis of 32 Cases) 393
- Grosz, Hanus J., M.D. (Nicotine Addiction: Treatment with Medical Hypnosis), Part 1 1074
Part 2 1136
- Guin, Jere D., M.D. (Clinical Notes: Dermatology) 333, 557
- Guin, Jere D., M.D. (Poison Ivy [Rhus] Dermatitis) 774
- Guin, Jere D., M.D. (The Treatment of Urticaria) 700

H

- Hall, Bernard R., M.D. (Oral Contraceptives and Thromboembolic Disease) 413
- Hall, James A., M.D. (Oral Contraceptives and Thromboembolic Disease) 413
- Hamm, R., Tech. (Non-Invasive Blood Flow Studies for Evaluating the Arterial and Venous Systems of the Legs and the Extracranial Carotid System in the Neck) 563
- Harvey, David M., M.D. (As I See It—IMPAC) 861
- Haynes, John T., M.D. (A Re-Evaluation of Ephedrine/Theophylline Combinations in the Treatment of Asthma) 492
- Hendrie, Hugh C., M.B., Ch.B. (Depression in the Elderly) 983
- Herring, Malcolm B., M.D. (Notes from the Royal College of Surgeons of England) 16, 841
- Hicks, Edward J., M.D. (Further Observations on New Tube Tests for Rapid Detection of Hemoglobin S) 692
- Hicks, George W., M.D. (Reconstructive Ear Surgery) ... 694

- Hill, Lloyd L., M.D. (An Important Message: For Reference Committee Members) 659
- Hillis, J. Stanley, M.D. (Complications of Acute Anterior Myocardial Infarction) 470
- Hilz, J. M., M.D. (Non-Invasive Blood Flow Studies for Evaluating the Arterial and Venous Systems of the Legs and the Extracranial Carotid System in the Neck) 563
- Hoke, Stanley R., B.A. (Screening for Congenital Hypothyroidism Using an Insolubilized Radio Immunoassay Technique) 689

J

- Jay, Stephen J., M.D. (Current Concepts in the Management of Pulmonary Tuberculosis) 763
- Jean, Thomas A., M.D. (Abdominal Pregnancy, Full Term: A Case Report and Review of Literature) 330
- Jegen, Lawrence A., III, J.D. (Tax Tips) .. 111, 342, 376, 538, 671, 742, 820, 975, 1114
- Johnson, John C., M.D. (Indiana Paramedic Ambulance Personnel Gain State Certification) 964
- Johnson, Mark R., M.D., Oklahoma (Present for Duty, Sir! —Guest Editorial) 956
- Johnstone, Douglas F., M.D. (Notes from Down Under) 80, 754

K

- Kiggins, M. S., Tech. (Non-Invasive Blood Flow Studies for Evaluating the Arterial and Venous Systems of the Legs and the Extracranial Carotid System in the Neck) . 563

L

- Lehman, Joe G., M.A. (The I. U. Physician: 1903-1978) . 968
- Loh, Wei-Ping, M.D. (Further Observations on New Tube Tests for Rapid Detection of Hemoglobin S) 692
- Loh, Wei-Ping, M.D. (Legionnaire's Disease: A Case Report with Review of Literature) 994
- Luft, Friedrich C., M.D. (Hypertension VIII: Hypertension in the Patient with Renal Failure) 104
- Luft, Friedrich C. (The Causes and Medical Treatment of Urinary Calculi) 678
- Lukemeyer, George T., M.D. (The Bitter Fruits of a Coal Strike—Guest Editorial) 440
- Lukemeyer, George T., M.D. (Guest Editorial) 77

Mc

- McDougal, Robert A., M.D. (Screening for Colon/Rectum Cancer) 411

M

- Mandelbaum, Isidore, M.D. (Oral Contraceptives and Thromboembolic Disease) 413
- Mannion, Rodney A., M.D. (Creation of Pelvic Tamponade by Deliberate Ureteral Obstruction in Treatment of Intractable Unilateral Renal Bleeding) 336
- Mannion, Rodney A., M.D. (The Scalpel and the Pen: Francois Rabelais 1004
Tobias George Smollett) 706
- Manning, George C., M.D. (Cost Containment: Where the Monkey is) 953
- Moss, H. C., M.D. (Sterilization Restrictions: A Critique of Rules Proposed by DHEW) 390

N

Napier, G. E., L.P.N. (Non-Invasive Blood Flow Studies for Evaluating the Arterial and Venous Systems of the Legs and the Extracranial Carotid System in the Neck) .	563
Neville, William E., M.D. (Surgical Experience with Pulmonary Tuberculosis Patients Receiving Steroids)	1138
Noble, Joe R., M.D. (Complications of Acute Anterior Myocardial Infarction)	470
Nordschow, Carleton D. (Screening for Congenital Hypothyroidism Using an Insolubilized Radio Immunoassay Technique)	689
Noveroske, Richard J., M.D. (Up with 'Polyvim'—Down with Heterosis—Guest Editorial)	522
Noveroske, Richard J., M.D. (There's a Word for It: Brachiocephalic Artery	378
Collapse of a Lung	18
Disease	746
Distal Expansion of the Radius	464
Gas-Liquid Level	328
Hip Bone	77
Low Sodium Diet	1012
Radiology	705
Scaphoid Bone	746
Technologist)	1122
Noveroske, Richard J., M.D. (Tolerance of the Vermiform Appendix to Pressure)	1144
Noveroske, Richard J., M.D. (Why Does the Earth Turn?)	1048

O

Oei, Tijen O., M.D. (Newborn Screening: Rationale, Methods, Responsibilities)	686
Oei, Tijen O., M.D. (Screening for Congenital Hypothyroidism Using an Insoluble Radio Immunoassay Technique)	689
Okorafor, Godwin, M.D. (Rupture of Abdominal Aortic Aneurysm into Vena Cava: A Report of Two Cases) ..	90

P

Pifarre, Roque, M.D. (Surgical Experience with Pulmonary Tuberculosis Patients Receiving Steroids)	1138
Porter, George S., M.D. (Cornual Pregnancy: A Case Report)	94
Porter, George S., M.D. (The Fountain of Youth or Where is the Estrogen Coming From)	997
Powell, Richard C., M.D. (HDL Cholesterol and Atherosclerosis)	551
Pratt, J. Howard, M.D. (Pheochromocytoma: Diagnosis and Management)	1076

R

Raghuath, T. K., M.D. (Surgical Experience with Pulmonary Tuberculosis Patients Receiving Steroids)	1138
Rahmany, M. A., M.D. (The Treatment of Hyponatremia) ..	488
Rapp, George F., M.D. (Spinal Screening for Scoliosis, Kyphosis and Lordosis)	33
Rohn, Robert J., M.D. (Platelet Studies as a Measure of Coagulative Integrity of the Surgical Patient)	325
Rolley, Ronald T., M.D. (Heel Ulcer Development and Successful Arterial Reconstructive Surgery)	1142
Roubush, Corbin P., M.D. (Radiation-Associated Thyroid Cancer)	780
Roubush, Corbin P., M.D. (Thyroid Function Tests for the Practicing Physician)	837

Ryder, Kenneth W., M.D. (Screening for Congenital Hypothyroidism Using an Insolubilized Radio Immunoassay Technique)	689
--	-----

S

Scea, Wallace A., M.D. (Letter to the Editor: Free Us From This Bondage!)	445
Schreiner, Richard L., M.D. (Infants of Diabetic Mothers) ..	409
Schreiner, Richard L., M.D. (Necrotizing Enterocolitis in the Newborn: Analysis of 32 Cases)	393
Schreiner, Richard L., M.D. (Neonatal Hypoglycemia) ..	485
Schreiner, Richard L., M.D. (Newborn Thyroid Screening: Rationale, Methods, Responsibilities)	686
Shula, Robert J., J.D. (One Doctor's Rx for a Malpractice Suit: Countersue)	106
Siderys, Harry, M.D. (Coronary Artery Endarterectomy: Its Role in Myocardial Revascularization)	835
Siderys, Harry, M.D. (Rupture of Abdominal Aneurysm into Vena Cava: A Report of Two Cases)	90
Smitherman, Marvin L., M.D. (Catheter Complications with Total Parenteral Nutrition in the First Year of Life) Part 1	478
Part 2	554
Stadler, Harold E., M.D. (Infantile Rickets)	1072
Stein, Mark, M.D. (Necrotizing Enterocolitis in the Newborn: Analysis of 32 Cases)	393
Stevens, Dennis, M.D. (Infants of Diabetic Mothers)	409
Stevens, Dennis, M.D. (Neonatal Hypoglycemia)	485
Stevenson, Jessie M. (Coffee: Good for What Ails You?) .	96
Swaim, J. Franklin, M.D. (A Study in Longevity)	771

T

Theobald, Dale E., Ph.D. (Raynaud's Phenomenon: Treatment of a Severe Case with Biofeedback)	990
Troeger, Thomas A., M.D. (North Central Indiana Physician Distribution and Projection Study)	567
Tsung, Swei H., M.D. (Immunoblastic Lymphadenopathy). ..	1068

U,V,W

Upton, Arthur C., M.D. (National Cancer Program—Cancer and Estrogen Use)	732
Waldrop, Betty J., R.N., M.A. (A Survey of Three Western Indiana Rural Community Health Centers)	381
Wambo, John M., M.D. (Cornual Pregnancy: A Case Report)	94
Wambo, John M., M.D. (The Fountain of Youth or Where is the Estrogen Coming From)	997
White, Arthur C., M.D. (Legionnaire's Disease)	35
Wehlage, David F., M.D. (Psychotherapy: What Is It?) . .	1079
Wiland, Olin K., M.D. (The Fountain of Youth or Where is the Estrogen Coming From)	997
Williams, Mrs. H. S. (Screening for Colon/Rectum Cancer) ..	411
Williams, Stephen D., M.D. (Current Concepts in the Evaluation and Treatment of Hodgkin's Disease)	402
Wright, James C., M.D. (Newborn Thyroid Screening: Rationale, Methods, Responsibilities)	686
Wright, J. William III, M.D. (Reconstructive Ear Surgery) ..	694
Wright, J. William, Jr., M.D. (Reconstructive Ear Surgery) ..	694
Wynn, Ralph J., M.D. (Newborn Thyroid Screening: Rationale, Methods, Responsibilities)	686
Wynn, Ralph J., M.D. (Screening for Congenital Hypothyroidism Using an Insolubilized Radio Immunoassay Technique)	689

Index to Volume 71

X, Y, Z

Yaw, Peter B., M.D. (Survival Rates of Major Abdominal Vascular Injury in an Eight-Year Period)	776	Ziegler, Richard, M.D. (Current Concepts in the Management of Pulmonary Tuberculosis)	763
Zahm, Michael, M.D. (Survival Rates of Major Abdominal Vascular Injury in an Eight-Year Period)	776	Zvetina, James R., M.D. (Surgical Experience with Pulmonary Tuberculosis Patients Receiving Steroids)	1138

DEATHS

Arbuckle, William E., Sr., M.D., Indianapolis	61	Middleton, Harvey N., M.D., Indianapolis	580
Benz, Jesse C., M.D., Salem	61	Mitchell, John B., M.D., Evansville	580
Brock, Joseph T. (Buddy), M.D., New Castle	512	Modisett, Jackson W. (Jack), M.D., Madison	580
Burwell, Stanley W., M.D., Muncie	722	Moser, Rollin H., M.D., Indianapolis	940
Cagle, Bob R., M.D., New Palestine	1020	Nesbitt, Leonard Locke, M.D., Anderson	1020
Curtner, Myron L., M.D., Vincennes	61	Omstead, Milton H., M.D., Petersburg	722
Davidson, Harold Hall, M.D., Evansville	798	Pauszek, Thomas B., M.D., South Bend	1020
DeMotte, C. Bowen, M.D., Greenwood	512	Pulskamp, Bertrand H., M.D., Wolcottville	798
Dodds, James U., M.D., Hartford City	61	Quigley, Joseph B., M.D., Indianapolis	512
Donovan, Thomas G., M.D., Evansville	580	Rhind, Alexander W., M.D., Hammond	430
DuBois, Charles C., M.D., Warsaw	430	Scheurich, Virgil, M.D., Oxford	430
Eaton, Marion J., M.D., Lafayette	512	Schulfer, Richard J., M.D., Hammond	512
Everly, Ralph V., M.D., Indianapolis	1020	Shapiro, Joseph, M.D., East Chicago	580
Feinn, Harry S., M.D., LaPorte	1160	Sherwood, Clarence E., M.D., Brookings, S.D.	1160
Foster, Ray T., M.D., New Castle	580	Silverman, Norman M., M.D., Terre Haute	580
Garceau, George J., M.D., Indianapolis	126	Sparks, Alan L., M.D., Indianapolis	1160
Gossom, Donn R., M.D., Terre Haute	512	Spears, John K., M.D., Paoli	126
Green, W. L., M.D., Shelbyville	126	Springstun, W. Russell, M.D., Evansville	940
Grorud, Alton C., M.D., South Bend	61	Swan, John R., M.D., Indianapolis	430
Hadley, David, M.D., Indianapolis	1160	Teixler, Victor A., M.D., Indianapolis	798
Hammel, Howard T., M.D., Bedford	722	Thornton, Harold C., M.D., Indianapolis	430
Hampshire, Donald R., M.D., Indianapolis	940	Tiley, George A., M.D., Greenwood	126
Harless, Clarence M., M.D., Chesterton	512	Tindall, William R., M.D., Indianapolis	430
Harstad, Casper (Cap), M.D., Rockville	940	Tyrrell, Sallie, M.D., Calumet City, Ill.	1020
Hicks, Murwyn L., M.D., Indianapolis	126	Voyles, Harry E., Sr., M.D., New Albany	512
Horwitz, Thomas, M.D., Indianapolis	61	Waggener, James A., Indianapolis	722
Howe, Fordyce L., M.D., Fort Wayne	61	Wallace, Elmer L., M.D., New Albany	430
Jay, Arthur N., M.D., Indianapolis	940	Walter, Paul A. F., III, M.D., Evansville	1020
Jolly, Wesley J., M.D., Richland	126	Webster, Robert K., M.D., Brazil	430
LaSalle, Robert M., Sr., M.D., Wabash	126	White, Donald G., M.D., South Bend	61
Lawler, George F., M.D., Indianapolis	61	Williams, Fielding P., M.D., Huntingburg	580
Lee, Glen Ward, M.D., Richmond	512	Wood, Opal L., M.D., Brazil	940
McBride, J. William, M.D., Michigan City	940	Wright, Cecil S., M.D., Anderson	722
McClure, Stanley E., M.D., Monon	1020	Zaring, Byron K., M.D., Columbus	940

COUNTY MEDICAL SOCIETY DIRECTORY

County

Adams
Allen (Fort Wayne)

Bartholomew-Brown
Benton
Boone
Carroll
Cass
Clark
Clay
Clinton
Davies-Martin
Dearborn-Ohio
Decatur
DeKalb
Delaware-Blackford
Dubois
Elkhart
Fayette-Franklin
Floyd
Fountain-Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison-Crawford
Hendricks
Henry
Howard
Huntington
Jackson
Jasper
Jay
Jefferson-Switzerland
Jennings
Johnson
Knox
Kosciusko
LaGrange
Lake

LaPorte

Lawrence
Madison
Marion

Marshall
Miami
Montgomery
Morgan
Newton
Noble
Orange
Owen-Monroe

Parke-Vermillion
Perry
Pike
Porter
Posey
Pulaski
Pulnam
Randolph
Ripley
Rush
St. Joseph

Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh
Vigo

Wabash
Warrick
Washington
Wayne-Union
Wells
White
Whitley

President

John E. Doan, Decatur
Jerald L. Andrew, Fort Wayne

Robert G. Reed, Columbus
A. L. Coddens, Earl Park
Donald Boyer, Lebanon
Stephen C. Mayers, Flora
Joseph Howard, Logansport
Joselito Millan, Jeffersonville
Robert C. Oehler, Brazil
Milton Erdel, Frankfort
Marshall Seat, Washington
Henry Conrad, Lawrenceburg
Gene P. Gebele, Greensburg
John C. Harvey, Auburn
David J. Dietz, Muncie
Allen D. Scales, Huntingburg
Donald L. Minter, Goshen
Joseph L. Steinem, Connorsville
William V. Craft, New Albany
Hugh C. Brenner, Williamsport
James P. Schalliol, Rochester
William Wells, Princeton
L. J. Wojcik, Marion
Robert Moses, Worthington
A. Adrian Lanning, Noblesville
Carl K. Matlock, Greenfield
Louis M. Blessinger, Corydon
Joseph Kerlin, Danville
David Cain, New Castle
G. M. Reul, Kokomo
William J. Webb, Huntington
Mark M. Bevers, Seymour
Kenneth J. Ahler, Rensselaer
James S. Fitzpatrick, Portland
Robert Mulford, Versailles
James L. Calli, North Vernon
Steven A. Weber, Franklin
James A. Koontz, Vincennes
David W. Haines, Warsaw
Millard R. Taylor, Howe
Thomas A. Gehring, Merrillville

Barbara Backer, LaPorte

Gerald E. Kasting, Bedford
Kenneth E. Schemmer, Anderson
George T. Lukemeyer, Indianapolis

Michael F. Deery, Culver
Maurice Sixbey, Denver
Fred P. Warbinton, Crawfordsville
O. R. Wilson, Morgantown
R. S. Jardenil, Kentland
John E. Ramsey, Kendallville
Charles X. McCalla, Paoli
William R. Anderson, Bloomington

George Alexandrescu, Clinton
Robert Gilbert, Tell City
Donald L. Hall, Petersburg
James R. Brown, Valparaiso
Harold E. Ropp, New Harmony
Harold J. Halleck, Winamac
Fred Haggerty, Greencastle
Jerome M. Leahey, Union City
Manuel G. Garcia, Batesville
Davis W. Ellis, Rushville
Richard Schaphorst, Mishawaka

Benjamin V. Roberto, Austin
Lucian A. Arata, Shelbyville
Michael O. Monar, Rockport
Walter Fritz, Knox
Donald Mason, Angola
John R. Taylor, Palestine
Altamont Bracey, Lafayette
Destroy W. Lambert, Tipton
Wallace M. Adye, Evansville
Tom J. Conway, Terre Haute

Charles R. Lyons, Wabash
Robert C. Colvin, Newburgh
Charles B. Carly, Pekin
William R. Stilwell, Richmond
Louis F. Bradley, Bluffton
Max L. Fields, Monticello
Claude J. Heritier, Columbia City

Secretary

Hyung Soo T. Lee, 227 S. Second St., Decatur 46733
Robert W. Dettmer, 2828 Fairfield Ave., Fort Wayne 46806
Mr. Larry L. Pickering, Exec. Dir., 212 Med. Cir. Bldg., Fort Wayne
Stanley R. Adkins, 380 Plaza Drive #D, Columbus 47201
Manley K. Scheurich, R.R. 1, Oxford 47971
John J. Saalwaechter, 404 W. Camp St., Lebanon 46052
Robert Seese, 101 W. North St., Delphi
Carl R. Boyd, 2 Chase Park, Logansport 46947
Jerrold E. Tamlin, 1220 Spring St., Jeffersonville 47130
E. L. Conrad, 1207 E. National Ave., Brazil
William R. Stapleton, 1256 S. Jackson, Frankfort 46041
James P. Beck, 1312 Bedford Rd., Washington 47501
Gerald T. Bowen, 705 Tanner Ave., Lawrenceburg 47025
Arnold D. Ducanes, 215 N. Franklin St., Greensburg 47240
Harland V. Hippensteel, 208 W. 7th St., Auburn 46706
Chas. J. Leiphart, 320 W. Adams St., Muncie 47305
Phillip R. Dawkins, 507 W. 7th St., Jasper 47546
Page E. Spray, 320 W. High St., Elkhart
Kirit T. Patel, 1941 Virginia Ave., Connorsville 47331
Daniel H. Cannon, 1201 E. Spring St., New Albany
Theodore Person, 601 N. Mill St., Veedsburg
Joseph D. Richardson, 121 West 8th St., Rochester 46975
Hassan Rayes, 1814 Sherman Dr., Princeton 47670
E. S. Rifner, Van Buren
Harry Rotman, Jasonville
Paul M. Waitt, 450 Lafayette Rd., Noblesville 46060
Gary C. Sharp, 120 W. McKenzie, Greenfield 46140
Carl E. Dillman, Beaver & Oak St., Corydon 47112
Wm. A. Edwards, 1655 Hawthorn Dr., Plainfield 46168
Donald E. Vivian, Henry Co. Hospital, New Castle 47362
Donald L. Fields, 3804 Southland Ave., Kokomo 46901
Piyush J. Shah, 1159 Etna Ave., Huntington 46750
Joel M. McGill, 213 E. Cross St., Brownstown 47220
Michael Louck, 828 W. Washington Ave., Rensselaer 47978
Joseph F. Vormohr, 604 W. Arch St., Portland 47371
Ott B. McAfee, Madison State Hospital, Madison
F. Richard Walton, 311 Henry St., North Vernon 47265
Chandrabhan Singh, Johnson Co. Memorial Hospital, Franklin 46131
Jay R. Tuttle, 14 S. Third St., Vincennes 47591
George A. Ros, 827 S. Union St., Warsaw 46580
Evan C. Thompson, P.O. Box 217, Topeka 46571
Mary E. Carroll, 124 N. Main St., Crown Point 46307
Mr. John B. Twyman, Ex. Dir., 6685 Broadway, Merrillville 46410
Robert M. Kelsey, 1200 Michigan Ave., LaPorte 46350
Orville A. Schumm, Exec. Dir., 110 South Ave., La Porte 46350
Gareth A. Morgan, 1618—24th St., Bedford 47421
John D. Jones, 1719 N. Madison Ave., Anderson 46012
George H. Rawls, 3151 N. Illinois St., Indianapolis 46208
Mr. Harold W. Hefner, Exec. Dir., 211 N. Delaware St., Indianapolis 46204
Byron Holm, 304 N. Walnut, Plymouth 46563
A. L. Baluyut, 29 E. Main, Peru 46970
Jack L. Foltz, 1407 Darlington Ave., Crawfordsville 47933
Stephen L. Hardin, 171 E. Washington St., Martinville 46151
E. L. Gamba, Lake Village 46349
Carl F. Stallman, R.R. 3, Kendallville 46755
Philip T. Hodgins, Orleans
Mark Wisen, 619 W. First, Bloomington 47401
Arlene Rhea, Exec. Secy, 1920 E. Third St., Bloomington 47401
J. Franklin Swaim, P.O. Box 185, Rockville 47872
Robert A. Ward, Professional Bldg., Tell City
Donald L. Hall, 7th and Poplar, Petersburg 47567
Uldarico B. Blando, 802 LaPorte Ave., Valparaiso 46383
Herman Hirsch, 130 W. 5th St., Mt. Vernon
William R. Thompson, 111 N. Monticello St., Winamac 46996
F. R. Dettloff, 407 Melrose Ave., Greencastle 46135
C. R. Miranda, 702 Browne St., Winchester 47394
Thomas E. LeBeau, Margaret Mary Hospital, Batesville 47006
Harry G. McKee, 208 W. First St., Rushville 46173
Richard Buck, 51916 U.S. 31 North, South Bend 46615
Mrs. Rose Vance, Exec. Secy., 2015 Western Ave., South Bend 46629
Manuel T. Dancel, 675 N. Gardner St., Scottsburg 47170
Dar Muceno, 103 W. Washington, Shelbyville 46176
John C. Glackman, Jr., Rockport
Earl Leinbach, Hamlet
K. L. Kissinger, 411 E. Eilmore St., Angola 46703
Joe Dukes, South Third St., Dugger 47848
Robert Williamson, c/o 2424 Ferry St., Lafayette 47904
George L. Compton, 219 N. Independence, Tipton 46072
Mrs. Carole Rust, Exec. Dir., 421 N. Main St., Evansville 47711
James W. Cristee, 400 8th Ave., Terre Haute 47804
William L. Purcell, Exec. Secy., P.O. Box 986, Terre Haute
Parks M. Adams, Jr., 1103 N. Wayne St., N. Manchester 46962
Wm. G. West, Jr., P.O. Box 558, Newburgh 47630
Thomas R. Northcott, 102 N. Harrison, Salem 47167
Richard M. Butler, Reid Memorial Hospital, Richmond 47374
James E. Umphrey, 303 S. Main St., Bluffton 46714
Nolan A. Hibner, 222 S. Main St., Monticello 47960
John Vogel, 215 E. Van Buren, Columbia City 46725

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

1979 Annual Meeting—Oct. 13-17—Indianapolis

OFFICERS FOR 1978-79

President—James A. Harshman, St. Joseph Hospital, Kokomo 46901

President-Elect—Arvine G. Popplewell, 3530 S. Keystone, Indianapolis 46227

Treasurer—Joseph F. Ferrara, 111 S. Water St., Franklin 46131

Assistant Treasurer—Douglas H. White, 3524 N. Meridian, Indianapolis 46208

Executive Committee—Paul W. Holtzman, Chairman; James A. Harshman, Arvine G. Popplewell, Joseph F. Ferrara, Douglas H. White, Lloyd L. Hill, Lawrence E. Allen, John W. Beeler, Eli Goodman, Alvin J. Haley, Members
Speaker of the House—Lloyd L. Hill, 302 N. Duke St., Peru 46970

Vice Speaker—Lawrence E. Allen, 2009 Brown St., Anderson
Executive Director—Mr. Donald F. Foy

TRUSTEES

District	Term Expires
1—John A. Bizal, Evansville	Oct. 1980
2—Harold M. Manifold, Bloomington	Oct. 1981
3—Thomas A. Neathamer, Jeffersonville	Oct. 1979
4—Howard C. Jackson, Madison	Oct. 1980
5—Paul Siebenmorgen, Terre Haute	Oct. 1981
6—Davis W. Ellis, Rushville	Oct. 1979
7—Donald C. McCallum, Indianapolis	Oct. 1980
8—John G. Pantzer, Indianapolis	Oct. 1981
9—Jack M. Walker, Muncie	Oct. 1981
10—John A. Knote, Lafayette	Oct. 1979
11—Martin J. O'Neill, Valparaiso	Oct. 1980
12—Herbert C. Khalouf, Marion	Oct. 1981
13—Alvin J. Haley, Fort Wayne	Oct. 1979
14—Donald S. Chamberlain, South Bend	Oct. 1980

ALTERNATES

District	Term Expires
1—E. DeVerre Gourieux, Evansville	Oct. 1979
2—Edgar R. Cantwell, Vincennes	Oct. 1980
3—Richard G. Huber, Bedford	Oct. 1980
4—Mark M. Bevers, Seymour	Oct. 1979
5—William G. Bannon, Terre Haute	Oct. 1979
6—Dan W. Hibner, Richmond	Oct. 1981
7—L. E. Michael, Indianapolis	Oct. 1979
8—Gerald J. Kurlander, Indianapolis	Oct. 1979
9—Ted S. Doles, Middletown	Oct. 1979
10—Max N. Hoffman, Covington	Oct. 1980
11—Leonard W. Neal, Munster	Oct. 1981
12—Fred C. Poehler, La Fontaine	Oct. 1980
13—Franklin A. Bryan, Fort Wayne	Oct. 1980
14—John W. Luce, Michigan City	Oct. 1979

SECTION OFFICERS 1978-79

Section on Surgery

Chairman—Glen McClure, Sullivan
Secretary—James A. Madura, Indianapolis

Section on Internal Medicine

President—Douglas H. White, Indianapolis
Secy-Treasurer—William Bastnagel, Indianapolis

Section on Family Practice

Chairman—Bernard J. Emkes, Indianapolis
Secretary—Edwin E. Stumpf, New Haven

Section on Neurological Surgery

Chairman—Louis W. Conway, Lafayette
Secretary—Daniel F. Cooper, Indianapolis

Section on Ophthalmology and Otolaryngology

Chairman—John Bizal, Evansville
Secretary—Daniel R. Evans, Valparaiso

Section on Anesthesiology

Chairman—Normand Townley, Indianapolis
Secretary—Wendell Edwards, Indianapolis

Section on Public Health and Preventive Medicine

Chairman—Robert K. McKechnie, Jeffersonville
Secretary—David J. Edwards, Indianapolis

Section on Radiology

Chairman—William J. Miller, Lafayette
Secretary—Wallace S. Tirman, South Bend

Section on Nervous and Mental Diseases

Chairman—Philip M. Morton, Indianapolis
Secretary—Jeffrey J. Kellams, Indianapolis

Section on Pathology and Forensic Medicine

Chairman—Robert Reed, Columbus
Secretary—David E. Smith, Indianapolis

Section on Pediatrics

Chairman—Robert Hannemann, Lafayette
Secretary—William C. Ashman, Fort Wayne

Section on Directors of Medical Education

Chairman—Barbara Backer, LaPorte
Secretary—Robert Chevalier, Beech Grove

Section on Cutaneous Medicine

Chairman—Edward Probst, Columbus
Secretary—Patrick Logan, Indianapolis

Section on Allergy

Chairman—Paul D. Isenberg, Indianapolis
Secretary—Beauford Spencer, Bloomington

Section on Urology

Chairman—Russell L. Judd, Indianapolis
Secretary—David Schlueter, Fort Wayne

Section on Orthopedic Surgery

Chairman—Robert F. Kimbrough, Fort Wayne
Secretary—Morris S. Friedman, South Bend

Section on Emergency Medicine

Chairman—John C. Johnson, Brownsburg
Secretary—Esther Schubert, New Castle

DELEGATES TO THE AMA

Terms expire December 31, 1978:

Delegates: James A. Harshman, Kokomo; Malcolm O. Scamahorn, Pittsboro; Ross L. Egger, Daleville.

Alternates: George T. Lukemeyer, Indianapolis; Everett E. Bickers, Floyds Knobs; Gilbert M. Wilhelmus, Evansville.

Terms expire December 31, 1979:

Delegates: Patrick J. V. Corcoran, Evansville; Peter R. Petrich, Attica.

Alternates: Thomas C. Tyrrell, Hammond; Marvin E. Priddy, Fort Wayne.

DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place, Date of Meeting
1.	Forrest Radcliff, Evansville	William R. Wells, Princeton	May 17, 1979, Evansville
2.	Joe Dukes, Dugger	James P. Beck, Washington	1979, Sullivan
3.	John M. Paris, New Albany	Charles C. McCalla, Paoli	Clarksville
4.	Brockton L. Weisenberger, Columbus	John I. Cooper, Madison	May 9, 1979, Columbus
5.	J. B. Ko, Terre Haute	Clyde Jett, Seelyville	May 9, 1979, Terre Haute
6.	Hal R. Rhynearson, Fortville	Douglas Morrell, Rushville	May 2, 1979
7.	Stephen L. Hardin, Martinsville	M. O. Scamahorn, Pittsboro	May 16, 1979, Martinsville
8.	George A. Donnelly, Geneva	Eugene M. Gillium, Portland	June 13, 1979
9.	Adrian Lanning, Noblesville	John A. Knote, Lafayette	June 14, 1979
10.	Lee H. Trachtenberg, Munster	Barron M. F. Palmer, Hammond	June 6, 1979, Hobart
11.	Thomas R. Scherschel, Kokomo	Frederick C. Poehler, La Fontaine	Sept. 19, 1979, Kokomo
12.	Michael O. Mellinger, LaGrange	Robert H. Musselman, Fort Wayne	Sept. 13, 1979
13.	William A. Stark, Mishawaka	Michael G. Quinn, South Bend	Sept. 12, 1979, Michigan City

ISMA Committees and Commissions

COMMITTEES

EXECUTIVE

Paul W. Holtzman, Bloomington, chairman; James A. Harshman, Kokomo, president; Arvine G. Popplewell, Indianapolis, president-elect; Joseph F. Ferrara, Franklin, treasurer; Douglas H. White, Indianapolis, assistant treasurer; Alvin J. Haley, Fort Wayne, chairman of the Board of Trustees; Eli Goodman, Charlestown, immediate past president; John Beeler, Indianapolis, at large.

FUTURE PLANNING

Peter R. Petrich, chairman; Stanley M. Chernish, Indianapolis; Vincent J. Santare, Munster; Jack Shanklin, Vincennes; E. Henry Lamkin, Indianapolis.

MEDICAL EDUCATION FUND

Donald E. Wood, Indianapolis, chairman; J. O. Ritchey, Indianapolis; John W. Beeler, Indianapolis; Joe E. Dukes, Dugger; Jack M. Lockhart, Connersville.

GRIEVANCE

G. Beach Gattman, chairman, Elkhart; William G. Bannon, Terre Haute; George T. Lukemeyer, Indianapolis.

MEDICO-LEGAL

John W. Beeler, Indianapolis, chairman.

NEGOTIATIONS

Alvin J. Haley, Fort Wayne, chairman; John W. Beeler, Indianapolis; Leonard W. Neal, Munster; Donald C. McCallum, Indianapolis; Herbert C. Khalouf, Marion.

IMPAIRED PHYSICIAN

Gerald P. Johnston, Indianapolis, chairman; Richard W. Campbell, Indianapolis; Wallace R. VanDenBosch, Lafayette; Thomas E. Lunsford, Indianapolis.

COMMISSIONS

CONSTITUTION AND BYLAWS

Lester H. Hoyt, Indianapolis, chairman; Thomas Kandul, Evansville; Russell Dukes, Bloomington; Claude J. Meyer, Jeffersonville; Henry Conrad, Lawrenceburg; Warren Macy, Greencastle; C. G. Clarkson, Richmond; Loren H. Martin, Indianapolis; Wallace A. Scea, Elwood; John J. Saalwaechter, Lebanon; Frank Moxley Sturdevant, Valparaiso; Robert M. Brown, Marion; William R. Clark, Sr., Fort Wayne; John B. Guttman, Wakarusa.

CONVENTION ARRANGEMENTS

Stanley M. Chernish, Indianapolis, chairman; Eugene Austin, Evansville; James N. Topoligus, Bloomington; Richard McIlroy, Columbus; Fred Haggerty, Greencastle; James Johnson, Richmond; Thomas Alley, Indianapolis; Clarence Ashburn, Muncie; Max Hoffman, Covington; Daniel T. Ramker, Hammond; Shirley T. Khalouf, Muncie; T. A. Felger, Fort Wayne; Thomas A. Neathamer, Jeffersonville; Edward C. Wheeler, Indianapolis; John O. Hildebrand, South Bend; Garry L. Bolinger, Indianapolis.

LEGISLATION

Richard L. Reedy, Yorktown, chairman; L. Ray Stewart, Evansville; Paul J. Wenzler, Bloomington; Peter H. Livingston, Bedford; Edward L. Probst, Columbus; William Strecker, Terre Haute; Kenneth Woodman, Richmond; Martin Fundenberger, Indianapolis; Dennis Nicholas, Indianapolis; Leonard W. Neal, Munster; Tom Scherschel, Kokomo; Jerry Stucky, Fort Wayne; Robert M. Sweeny, South Bend; Paul Muller, Indianapolis; Dean Grove, Indianapolis; Malcolm O. Scamahorn, Pittsboro; John A. Knote, Lafayette.

PUBLIC RELATIONS

Marvin Priddy, Fort Wayne, chairman; Albert S. Ritz, Evansville; Thomas O. Middleton, Bloomington; Frank P. Lloyd, Indianapolis; Robert P. Acher, Greensburg; Greg Larkin, Greencastle; Ralph Lewis Rea, Greencastle; Richard Jordan, Corydon; John Osborne, Muncie; Kenneth J. Ahler, Rensselaer; Charles D. Egnatz, Schererville; Richard Glendenning, Logansport; Logan Dunlap, South Bend; Harry G. Becker, Indianapolis; Ross Egger, Daleville.

MEDICAL EDUCATION

Steven C. Beering, Indianapolis, chairman; Charles Hachmeister, Evansville; David A. Byrne, Bloomington; Richard Riehl, Jeffersonville; Brockton Weisenberger, Columbus; Clean Schauwecker, Greencastle; James R. Lewis, Richmond; Hunter Soper, Indianapolis; Eugene Gillum, Portland; T. Neal Petry, Delphi; Rex Joseph, Indianapolis; Shokri Radpour, Kokomo; Ronald Scheeringa, Fort Wayne; Wallace S. Tirman, Mishawaka; Thomas A. Gehring, Merrillville; Franklin A. Bryan, Fort Wayne; John R. Mader, Richmond; John F. Phillips, Indianapolis; John Roscoe, Indianapolis.

MEDICAL SERVICES

H. Marshall Trusler, Indianapolis, chairman; Wallace Adye, Jr., Evansville; Donald D. Cofield, Bloomington; Everett E. Bickers, Floyds Knobs; H. S. Riley, Madison; Paul E. Humphrey, Terre Haute; Joseph L. Steinem, Connersville; Albert Donato, Indianapolis; John MacDougall, Indianapolis; Theodore R. Hayes, Muncie; Carl Bruce Howland, Crawfordsville; R. James Bills, Gary; Regino B. Urgena, Marion; R. Wyatt Weaver, Angola; Jack Hannah, Elkhart.

Ad Hoc Committees

CAT SCANNERS

Donald Chamberlain, South Bend, chairman

IMMUNIZATION

Robert Parr, Indianapolis, chairman

DATA PROCESSING

James H. Gosman, Indianapolis, chairman

JOURNAL ON MICROFILM

Microfilmed copies of current as well as all back issues of THE JOURNAL are available through University Microfilm Services, a subsidiary of Xerox Corporation. The 35 mm film fits all standard viewers and provides THE JOURNAL in miniature at a savings on binding and storage costs. Write for information or send orders direct to University Microfilm Services, 300 North Zeeb Road, Ann Arbor, Mich. 48106.



"Efficiency is the key to your practice"

Graduates of P. C. I. are thoroughly trained in the most up-to-date methods as Medical Assistants (AMA accredited) and Medical Receptionists.

PROFESSIONAL CAREERS INSTITUTE

6321 La Pas Trail, Indianapolis, IN 46268

Telephone: (317) 299-6001

Are You Moving?

If so, please send change of address to Membership Dept., ISMA, 3935 N. Meridian St., Indianapolis, IN 46208, at least six weeks before you move.

Name _____

Address _____

City _____ State _____ Zip _____

County _____

IMPORTANT — Attach mailing label from your last Journal here.

ADVERTISERS IN THIS ISSUE

December 1978 Vol. 71 No. 12

American Fletcher National Bank 1150
Anacomp 1103

Beltone Electronics Corp. 1113
Blue Cross-Blue Shield 1105
Brown Pharmaceutical Co., Inc. 1127
Burroughs Wellcome Co. 1101

Giganti, Inc. 1160

Hanger Protheses 1154

Immke Circle Leasing, Inc. 1155
Indiana Medical Bureau 1135

Lilly, Eli and Company, Inc. 1111

McClain Car Leasing, Inc. 1152
Mead Johnson Pharmaceutical Div. ... 1107, 1108
Medical Protective Company 1122
Merrell-National, Inc. 1117
Morris Plan 1123

P&SLI 1132
Professional Careers Institute 1262

Roche Laboratories Covers
Rockwood Insurance Agency 1151

Smith, Kline & French 1118, 1124, 1125

The Upjohn Company 1115

In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

2

1



344844

